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The Journal of the Australian Branches of the British Medical Association.

VOL. I.—8TH YEAR—NO. 14. SYDNEY: SATURDAY, APRIL 2, 1921. PRICE 1s.

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—8TH YEAR. SYDNEY: SATURDAY, APRIL 2, 1921. No. 14.

An Address.[1]

By **C. Bickerton Blackburn, O.B.E., M.D., Ch.M. (Syd.),**
Retiring President of the New South Wales Branch of the British Medical Association.

In coming before you to-night I feel, for the first time, a faint tinge of regret that the sea through which I have nominally piloted the Branch during the past twelve months has been so smooth and unruffled. I have found the log a dull and uninteresting record and I am sore put to it for matter for my address.

Yet your Council is conscious of much arduous and continuous work, for even in fair sailing weather there is much that has to be done. A year's work on the Council implies the spending of many hours on many nights in this room. Were it not for the numerous subcommittees, each of which attends to special aspects of the work, it would be impossible to get through the mass of details that crop up.

If one subcommittee can be singled out for your special thanks it is, I think, that of Organization and Science. I feel sure that you will all agree that the proceedings of the ordinary and clinical monthly meetings have been of exceptional interest. It must be extremely gratifying to the country members to know that this committee is at present collaborating with the University authorities in preparing a syllabus for a course of post-graduate work about the close of the year.

Our most unpleasant duty has been that of persuading you of the necessity of the raising of the annual subscription to five guineas. It is in a way unfortunate that this necessity has arisen during a year when everything has proceeded so smoothly that the average member has had little to remind him of how vitally his interests are bound up in the solidity of the Association.

By most of you the past year will be chiefly remembered on account of the very satisfactory new agreement that was so amicably arranged between this Branch and the friendly societies. Those who have sat on the Council, however, will perhaps best remember this term of office for its having synchronized with the visit of His Royal Highness the Prince of Wales.

It is, I think, generally conceded that one of the perquisities of the Presidential office, is the opportunity it gives to each holder on his retirement of expatiating upon his favourite theme for the time being, so I feel I need offer no apology for following so time-honoured a custom.

The subject I wish you to consider with me to-night is the art of prescribing as practised at the present day.

Can we congratulate ourselves upon making the same scientific progress in our therapeutics as in many other branches of medical knowledge? The pharmacologist, proudly recalling the magnificent record of chemical, physiological and clinical observations of recent years, will hotly contend in the affirmative. But what would be the reasoned judgement of a special commissioner appointed to inspect the last thousand prescriptions dispensed in this city? And what would be his final report if he were also clothed with power to question the prescribers as to what they knew about the various drugs and preparations ordered, apart from what they had gleaned from advertisements?

When we turn over the leaves of medical treatises written a century or more ago, we are prone to smile over some of the components of many of the wonderful mixtures that our predecessors thoughtfully and often laboriously compounded. We are amazed at the faith of those great clinicians in so many of the remedies that we know have long since been discarded as valueless. We find the same limited series of drugs recurring again and again, but if we are on the watch, we find now and then some new preparation making its appearance and not infrequently we find a reference to its introduction as the result of reports of its value brought back by one who has travelled in distant parts. We like to think of the greater ones carefully trying out each new remedy over a long series of cases before deciding for themselves as to its true value and we realize that such novelties were so rare that there would be abundant time to try one out before another cure for the same disease would be likely to appear.

May we not suspect that among those who left us no treatises, there were some with less scientific leanings who would be apt to prescribe each new drug that came on the horizon without making any attempt to watch and record its effects.

How much more fortunate are we in many respects than those old-time physicians? We are provided with a pharmacopœia, purged from time to time of preparations proved to be valueless and assimilating at each revision any new remedy that reliable clinical observations have found to be of service. We also have at hand treatises upon pharmacology and therapeutics compiled by members of the profession who have made the clinical and physiological study of drugs their life work. From these works we can inform ourselves of the exact actions of the various drugs in the pharmacopœia and often of very cogent reasons why some of those still retained in that authoritative volume should be discarded.

Further, we have great manufacturing firms employing chemists highly trained in the most modern analytical and synthetic methods to provide us with our old well-tried drugs or their active principles in purer and better standardized forms.

So far the shades of our predecessors might well envy our lot. But our bed of roses is not bereft of thorns.

Taught at our *alma mater* to follow a narrow pathway, guided by the broad light of the pharmacopœia, we find ourselves constantly tending to stray into bypaths in pursuit of countless will-o'-the-whisps in the form of new remedies not listed in its pages. New

[1] Delivered at the Annual Meeting of the New South Wales Branch of the British Medical Association on March 18, 1921.

drugs, new foods, new secretions, new methods of administration are unceasingly brought under our notice. Each post brings its pile of advertisements and we find our medical journals interleaved with similar laudatory notices. No need in our day to seek out the traveller, for bag in hand he haunts our waiting rooms and dogs our footsteps.

Surely the time has come for us to take some reckoning and to decide upon what should be our policy under the new conditions. There is, I fear, a very real danger that, unless some guide is given by the more thoughtful members of the profession, the art of prescribing may be lost and with it the habit of scientific treatment with its implied careful observation of results. It seems almost inexcusable to remind you that the writing of a prescription implies the thoughtful consideration of what drugs are suitable for the patient under treatment, the recalling of the recognized dosage of each and the decision as to what actual dose shall be ordered on that occasion. The use of a proprietary mixture, on the other hand, substitutes the group treatment of patients for the individual, by the exhibition of a mixture of fixed proportions which cannot be varied to suit special features in the case either in the way of variation of the dosage of some constituents or in the exclusion altogether of others. There is the added disadvantage that in many cases the prescriber is ignorant of the exact constitution of the preparation he is using.

Already there are apparently among us at least a sprinkling of optimists who are in the habit of giving a trial to practically every new drug brought under their notice without any idea of following up its effects, if we may judge by the rapid succession of the experiments. Should anyone doubt the accuracy of this statement, I would suggest that he pay a visit to the nearest dispensing chemist and ask to be shown the stock of partly used extra-pharmacopœial preparations. Inquiries as to when epidemics occur resulting in considerable additions to this vast store of bottles will probably elicit the information that it is sporadically, in the wake of travellers for the manufacturing firms, but that each epidemic rarely lasts long enough to enable the druggist to use more than a fraction of the supply he has had to purchase from the wholesale houses.

The difficulties in the way of the formulation of a policy that will satisfactorily combat these growing evils, are very great. To many the allurements of a well-advertised remedy seem well nigh irresistible and there is reason to fear that with many practitioners there is a feeling, perhaps more or less subconscious, that if a preparation is permitted to be advertised in the pages of their medical journal, this is some guarantee that it possesses the virtues ascribed to it. Such a conclusion is, of course, unjustified, for the medical journals have at least until quite recently, accepted no responsibility other than that of satisfying themselves that the advertising firms are reputable ones and do not deal directly with the public.

For some time past, however, the feeling has been growing up among the committees of management of the leading medical journals that they should shoulder a larger share of responsibility in the matter. One after another they have been extending their activities, chiefly, so far, in the direction of appointing skilled analysts to investigate various preparations submitted for advertisement, more particularly analysing foods and food preparations, in order to satisfy themselves that the constitution is as claimed by the maker. Among English speaking people, the *British Medical Journal*, *The Lancet* and the *Journal of the American Medical Association* have been for years engaged in this work. The committees of these papers have not only analysed preparations submitted to them, but have in numerous instances conducted analysis of remedies much advertised outside the medical press. The memorandum upon "secret remedies" placed in your hands some years ago may be mentioned as a result of some of these inquiries.

I am extremely gratified to be permitted to announce to-night that the Australasian Medical Publishing Company, Limited, that has charge of the publication of our own *Journal*, has just decided to undertake similar analysis of Australian preparations submitted for advertisement. This will, of course, entail considerable expense, but the outlay will be recouped by the increased prices obtained for advertising space. In time it is hoped that it will be possible to extend their activities.

However gratified we may feel about this step forward, the problem of supplying some criterion of the clinical value of drugs and other preparations still remains for solution. No journal committee has yet essayed to shoulder the Herculean task of carrying out clinical observations upon all the new remedies brought under their notice.

At first sight it might not seem unreasonable to expect manufacturers to supply unimpeachable clinical data with each new drug submitted to the profession. But how are they to obtain it and satisfy us that the observations are dependable? Already quasi-clinical reports are among the best baited traps for the unwary seeker after new remedies. Among the advertisements in his weekly medical news, a new trade name catches his eye and he reads that "following upon the report of Dr. X., of Y., upon the effect of," shall we say, "grape nuts in a series of cases of gravel, we now place before the medical profession this useful drug put up in our special containers, in 3 gramme doses. Dr. X. suggests that a suitable dosage is 1 gramme, three times daily. Supplied in bottles of 25: 10s." If the reader happens to know X. as a dear old dreamer in a tiny wayside village, his lateritious patients have to be content with their grape nuts in the old fashioned breakfast porringer. But what if Y. is in foreign parts? Dare we then deny the sufferers the new remedy in the approved containers?

Until this difficulty has been surmounted, I can offer no better advice than to follow the principles instilled into us all in our student days, some of which might be summarized thus:

To adopt the British Pharmacopœia as our medical Bible and to provide ourselves with a recent work on pharmacology and therapeutics to serve as a concordance.

To be chary in the use of any drugs not favourably mentioned in these volumes and only to use them when there are opportunities for thoughtful observation of their effects.

To write our own prescriptions and studiously avoid ordering any preparations of which we do not know the names, doses and actions of all the constituents.

To abstain from prescribing expensive remedies for those with slender means unless quite convinced that simpler and cheaper drugs will not be equally effective.

In concluding, I would like to express the hope that what I have said will not be taken as an unfavourable criticism of the great firms of manufacturing chemists to which we, as a profession, owe so tremendous a debt of gratitude, but rather as a warning against the haphazard use of the many new preparations which they submit for our approval.

PAPILLOMATA OF THE URINARY BLADDER.[1]

Treatment and After-Results.

By **S. Harry Harris, M.D., Ch.M. (Sydney),**

Honorary Urologist to the Lewisham Hospital; Honorary Urologist to the South Sydney Women's Hospital.

The material for this paper has been drawn from a review of the thirty-eight cases treated within the five-year period dating from January, 1914, to January, 1919.

This period has been selected as the methods of treatment were similar to those at present employed and a sufficient interval of time has been allowed to elapse to admit a fairly accurate estimate of the after-results.

Twenty-seven of the thirty-eight patients have been traced at times after treatment varying from one and a half to six and a half years. All are alive and free of trouble referable to the urinary tract. Six of the remaining eleven were seen at intervals up to six months after treatment and, though well at the time, could not be traced later. Of the remaining five, one died three days after operation from acute cardiac dilatation, one died from influenza four months after apparent cure and three could not be traced further than three months after treatment. These patients, though well at the time, cannot be included in the series for the purpose of estimating the value of treatment.

Of the total number of thirty-eight patients, thirty-three were treated throughout by the high frequency current through the cystoscope without mortality and five by suprapubic cystotomy with complete destruction of the tumours and entire mucous membrane of the bladder by the Paquelin (benzine) cautery—after the method of Beer. Of the latter, one died. This was the sole fatality during the five-year period. The remaining four patients so treated were well and free of recurrence at periods after operation ranging from one and a half to four and a half years. Three were suffering from very extensive multiple recurrences after previous suprapubic operation elsewhere; and the condition had been pronounced inoperable.

Of the thirty-three patients treated by the high frequency current, eight had more or less extensive—and in four cases multiple—recurrences after operation elsewhere by the suprapubic route. Of these, six are known to be well and free of recurrence at periods ranging from twenty months to four and a half years. The other two were well at the time of the last report, six months after the disappearance of the tumours.

In two of the total number of patients, the high frequency current was used in the first place and later open operation performed; the same procedure was adopted in one case, not included in the series, which proved to be a malignant infiltrating growth, with broad villous projections. In this last case a correct diagnosis was not made in the first instance, on account of the excessive hæmorrhage which was present at the time of the cystoscopic examination. The bleeding, however, diminished very materially after the treatment and a second cystoscopic examination revealed the true state of affairs. Of the two unsuccessful cases, one was that of a patient suffering from a large papilloma of the anterior wall and severe hæmaturia when he presented himself for the first of the two high frequency treatments which were given. There was immediate cessation of hæmorrhage and he failed to return after the second treatment until nearly twelve months had elapsed, although informed that there was still some growth remaining. Renewed hæmorrhage brought about his return to the hospital. He then had a very large growth on the anterior wall and open operation was performed. This patient could probably have been cured by the high frequency current; he was, however, of a low degree of intelligence and it was decided that further conservatism would be waste of time. In the other unsuccessful case there were innumerable papillomata scattered over the base and lateral walls of the bladder. The patient was a returned soldier and had been invalided home from Egypt on account of hæmaturia and had also a bullet lodged in his brain. He was, not unnaturally, extremely nervous and intolerant of treatment without anæsthesia, so that after two treatments open operation was decided upon. He made a complete recovery so far as his urinary tract was concerned.

Technique.

(*i.*) High-frequency treatment.
(*ii.*) Suprapubic operation.

I.—High Frequency Treatment.

The nomenclature of this method of treatment has given rise to a good deal of discussion. It has been variously styled "diathermy," "electro-coagulation," "high frequency cauterization," "desiccation" and other more or less applicable terms. It is in effect merely a painless and practical method of burning bladder tumours through the cystoscope with water distension.[1] As is now well known, the method was introduced by Beer of New York, in 1910. It consists in the application of the high frequency current to the bladder tumour by an insulated wire introduced through the cystoscope.

[1] Read before the Surgical Section of the Australasian Medical Congress, Brisbane, 1920.

[1] For microscopic changes *vide* appendix by Professor D. A. Welsh.

With the best types of high frequency machine, two currents are available, the unipolar and the bipolar. The effect of the unipolar current is more superficial and localized, while that of the bipolar current is a deep baking or thermo-penetration. The effect of both these currents differs from that of the usual cautery in that the heat is generated in the tissues themselves, the actual point of the electrode not being heated to any appreciable extent. The bipolar current, if used in sufficient strength, can destroy the vitality of almost any extent of tissue. (See Figures I. and II..) Greater care is accordingly necessary in its application than is the case with the unipolar current.

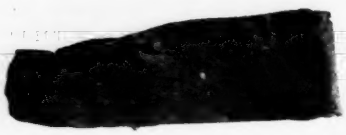

FIGURE I..
Effects of uni-polar high frequency current applied to raw beef steak for 15, 30 and 45 seconds. The area on the left side has been exposed for 15 seconds, that in the middle for 30 seconds and that on the right side for 45 seconds. Note the small, central areas of charring and the surrounding whitish necrotic areas.

As experience increases, one finds that the bipolar current almost entirely supplants the unipolar, except, perhaps, in the case of the smaller growths and when one is working near the bladder wall or vesical orifice. In competent hands the results are obtainable with equal safety and far greater expedition.

FIGURE II..
Results of bi-polar high frequency current applied as in Figure I.. The effect is much more intense.

In each case the high frequency machine is connected with the street current. Unless this is of the alternating type, an alternator must be interposed between the main and the high frequency machine. Large-sized platinum-tipped applicators (Nos. 9 and 10 F.) are used for large growths, Nos. 6, 7, 8 F. for smaller growths. For growths at the base of the bladder and in the neighbourhood of the ureteral orifices I prefer to use a Brown-Buerger operating cystoscope and for growths situated near the vesical orifice or on the anterior wall of the bladder (or for very large growths wherever situated), a Buerger cysto-urethroscope. This latter is a close-vision instrument and renders tolerably easy the treatment of growths in these otherwise difficult situations.

The cystoscopic applicators consist of non-fusible, insulated wire, encased as far as the base of the platinum points in silk catheters of the requisite size. A dry-cell battery or accumulator is used to light the cystoscope.

Where the bipolar current is used, a flat, wet pad electrode (15 cm. by 10 cm.) is placed under the sacrum or over the symphysis, depending on the site of the growth. With the unipolar current only the bladder terminal is employed. Otherwise the procedure in each case is practically identical.

An eight millimetre (¼ inch) spark gap is generally employed in the high frequency machine (the intensity of the application increasing with the length of the gap) and the current regulator is adjusted to give the desired effect.

The cystoscope is passed and the bladder well distended with tepid water. The cystoscopic applicator (which is passed through the cystoscope in the same manner as a ureteral catheter) is then connected with the high frequency terminal. The platinum-tip is pushed in amongst the villi of the tumour and the current turned on. No spark should appear. Gas bubbles are immediately emitted and the part of the tumour attacked first of all becomes blanched and, when a strong current is being used, miniature explosions in the growth may be heard. Finally, the portion of tumour assumes the appearance of an ordinary slough. (See Figures III., IV., IVA., V. and VI..)

Some surgeons use prolonged, continuous application of the current. Personally I rarely exceed thirty seconds and never exceed forty-five seconds for a single continuous application. As many separate applications are made as possible at each sitting, the aim being to leave no visible viable growth.

Local anæsthesia of the urethra alone is generally used. I do not, however, hesitate to employ general anæsthesia if the patient is intolerant of cystoscopy or otherwise over-anxious. In these circumstances caution must be exercised, as it would be an easy matter to burn the bladder wall. This cannot occur under local anæsthesia, as the patient gives immediate warning if the sensitive bladder wall is attacked.

The growth itself is quite insensitive and the treatment devoid of pain, unless the bladder is accidentally touched.

Confinement to bed or hospital is unnecessary between treatments. The patient, unless exsanguinated by previous hæmorrhage, can generally pursue his ordinary avocation.

Frequency of Treatments.

Since the burned portions of tumour are not, as a rule, cast off for at least ten or twelve days, this interval is usually selected. Unless, however, the growths be very large and numerous, I prefer to wait for three weeks, as marked regression often takes place in the third week. (Figure VI.) If all the growths have not been treated at the one sitting, more frequent *séances* may be made with advantage.

When the growth has been cauterized down to the mucous membrane, a longer interval is advisable before re-examination, in order that the heaped-up edge of the resulting ulcer and the surrounding œdema may have time to subside. (Figure VII.) Otherwise, portions of the latter may be mistaken for a papilloma (Figure VIII.) and an unnecessary burn be inflicted. Cases have even been recorded in which the appearance has been mistaken for the infiltration of a malignant growth and resection of the affected portion has been performed. This induration I have seen in several cases at as late a period as six weeks after cauterization. Cases have been recorded in which it has persisted for three months.

Number of Treatments.

With increasing experience I have found that fewer treatments are necessary to obtain the same results. The number of treatments in the latter half of this

FIGURE III..
(After Walker.) Note the position of the burnt tumour adhering to the electrode on its withdrawal.

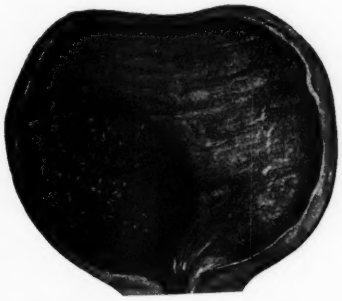

FIGURE IV..
(After Beer.) Illustrating a large papilloma overlying the right ureteral orifice and the right half of the trigone. (Before treatment.)

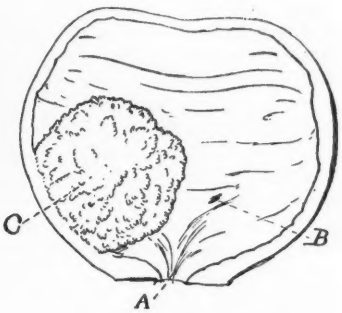

FIGURE IVA..
Diagram of Papilloma.

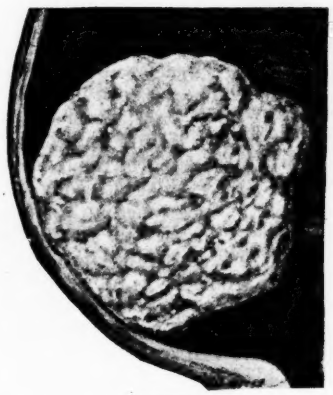

FIGURE V..
Same Case as Figure IV. (after treatment), showing complete necrosis of the surface of the growth before the separation of the sloughs.

FIGURE VI..
Same Case as Figures IV. and V. after the burnt portions of the tumour have separated, showing the original tumour to be composed of three sets of tumours. The right ureter and the trigone are now visible.

FIGURE VII..
(After Walker.) Showing resulting ulcer with heaped-up œdematous edges. The œdema may persist for six to twelve weeks and must not be mistaken for signs of malignancy.

series of cases averaged considerably less than 50% of those in the first half.

In seven of the 33 cases one sitting sufficed, in ten cases two, in seven cases three, in two cases four, in two cases five, whilst in four cases, six, seven, eight and nine sittings respectively were required. The average number for the whole series was three. The average length of time during which the current actually passed in each case was eight minutes.

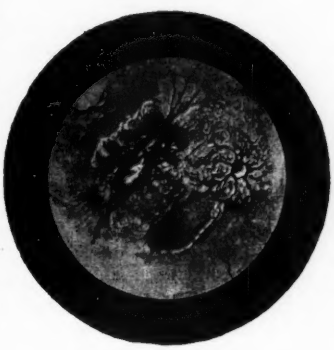

FIGURE VIII..
(After Walker.) Showing another type of ulceration with surrounding œdema immediately after the disappearance of the tumour.

Difficulties.

It is a confession of inexperience to suggest that the method is always simple and devoid of difficulties. These are mainly dependent on four factors: (*a*) the site of the growth or growths, (*b*) hæmorrhage, (*c*) sepsis, (*d*) size and multiplicity of the growths.

(*a*) Growths in the region of the base of the bladder and ureteral orifices are, as a rule, easy to treat. Those on the anterior wall and in the neighbourhood of the vesical neck are much more difficult. A practised cystoscopist will, however, seldom be compelled to desist on the score of inaccessibility.

(*b*) Hæmorrhage is in some cases a troublesome factor. This, however, will rarely prove insuperable. Persistent, unremitting hæmorrhage is a sign of malignancy and a contraindication to high frequency treatment.

(*c*) Sepsis of varying degree is frequently present. As a rule, this readily yields to local measures. Severe and intractable cystitis is commonly a sign of malignancy and a contraindication to high frequency treatment. In several of my cases treatment and sometimes diagnosis had to be deferred pending the relief of this condition.

(*d*) Size and multiplicity of the growths *per se* do not necessarily constitute any real difficulty. The measure of success attainable in these cases, unless they be associated with underlying malignant infil-

tration, will vary directly with the skill and patience of the operator.

Some patients, particularly men of stout, heavy build, are difficult to examine cystoscopically without general anæsthesia. This need not be withheld, provided that due care be exercised.

Cases Unsuitable for High Frequency Treatment.

Frankly malignant infiltrating growths are quite unsuitable for high frequency treatment, even as a palliative measure. If two or three applications do not effect a marked improvement, the high frequency treatment should not be continued. Resistance to treatment is pathognomonic of malignancy of an infiltrating type, which is not amenable to the high frequency current. Experience in cystoscopy in such cases is invaluable.

Complications.

The sloughs of burnt tissue sometimes begin to come away two or three days after cauterization, though usually not earlier than the second week. A sharp hæmorrhage may occasionally occur at this time. This will rarely require the passage of a catheter, or possibly aspiration of the clots by an evacuator. Patients should always be warned of this, in order both to prevent undue alarm and to insure appropriate treatment.

Noteworthy hæmorrhage has occurred only once in my experience and was controlled by the hypodermic injection of morphine and rest in bed for twenty-four hours.

Among two hundred cases collected by Beer in 1915 there were three instances of severe bleeding. Apparently hæmorrhage is one of those complications which, though it cannot be obviated with certainty, can be controlled by expert treatment.

FIGURE IX..
(After Walker.) Pitting of the bladder described as occurring in some cases after high frequency cauterization. This should be regarded as evidence of too prolonged, continuous application of the current at one particular point. Thirty seconds should rarely be exceeded for a single continuous application of the current.

The vague abdominal pains following the treatment reported by some operators are due, I believe, to a too prolonged, single, continuous application of the current to a particular portion of the tumour. More than thirty seconds for one continuous application should rarely be exceeded (Figure IX.).

Relapses.

It has been my practice not to consider the treatment of a case complete until examination three months after the last cauterization reveals the site of the tumour quite healed and free of papillomatous "buds." (Figure X..) In five cases in the series such "buds" were found at the site of the growth at the time of this examination. These each disappeared after one further burn. They should be regarded as evidence of incomplete treatment. With this as a standard procedure, there has not been a single known recurrence in the whole series of cases. All patients are advised to report for cystoscopic examination three times in the first year, twice in the second year and thereafter at yearly intervals.

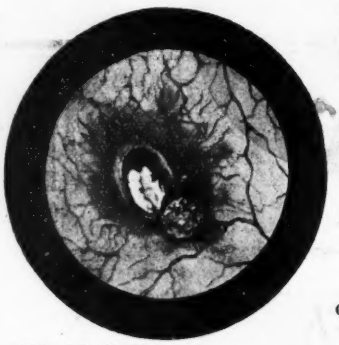

FIGURE X..
(After Walker.) A small papillomatous "bud" is here shown springing from the margin of an ulcer that has not yet healed. In no case may the treatment be considered complete till healing of any resulting ulcer has occurred and the entire neighbourhood is seen to be free of these "buds."

II. — TREATMENT BY SUPRAPUBIC OPERATION.

The following operative technique was employed in each of the five cases of this series:

After localization of the growth or growths by careful cystoscopy, the bladder is exposed by a free median suprapubic incision. The organ is freed from the wall of the pelvis on both sides and the peritoneum stripped well back from the fundus and, if necessary, incised and sewn to the back of the bladder at a lower level. The exposure must be sufficiently free to permit the bladder to be drawn well into the abdominal wound. The bladder is then freely incised in a vertical direction at a situation known to be free of growth. If any growths present in the incision, they are immediately burnt with the Paquelin cautery. The sides of the bladder are then widely retracted and a systematic cauterization made of any growths that are present and of the entire remaining mucous membrane of the bladder. No single portion of the interior of the bladder is left untouched. When this portion of the operation is completed, only charred tissue is visible inside the bladder. The lips of the bladder incision are carefully gone over with the cautery. About 30 c.cm. of rectified spirit are then poured into the bladder, thoroughly mopped over the interior and the excess removed. The bladder is repaired in the usual way, the drainage tube being placed at the highest part of the incision. The abdominal wound is sewn up in layers as usual, a small rubber-dam drain being placed in the space of Retzius.

The procedure briefly outlined above is tedious and time consuming, but otherwise presents no special technical difficulties. The actual operation time in each of the five cases varied from 75 to 90 minutes.

Cystoscopic examination of the four surviving patients six weeks after operation showed a mucous membrane healthy and but slightly whiter than normal. There was no evidence of scarring except at the line of the bladder incision. The bladder function of all was normal.

Tabulation of Results.

Total number of patients treated in five-year period, January, 1914, to January, 1919 ..	38
Treated by High Frequency Current Through the Cystoscope—	
Well at time of writing, 1½ to 6½ years after treatment	23
Well after six months, then disappeared ..	6
Well after four months, then died from influenza	1
Well after three months, then disappeared..	3
Total	33
Treated by Suprapubic Operation After Method of Beer—	
Well at time of writing, 1½ to 4½ years after operation	4
Died after operation	1
Total	5

Summary.

It will suffice to state that it has now been definitely proved that high frequency cauterization is the treatment *par excellence* for all papillomata of the bladder, benign or malignant, in which infiltration of the bladder wall has not occurred and that it yields incomparably better results than even the most radical operative procedure. It has been adopted by surgeons in practically every urologic clinic of any importance.

When for any good and sufficient reason open operation has to be undertaken, the method above described (originated by Beer) will probably yield a higher percentage of cures than the usual operative measures, which show a percentage of recurrences, variously estimated at from 30% to 60%.

Appendix.

THE MICROSCOPIC CHANGES IN MUSCLE AFTER EXPOSURE TO A HIGH FREQUENCY CURRENT FOR 15, 30 AND 45 SECONDS.

By **D. A. Welsh, M.A., M.D., F.R.C.P. (Ed.),**
Professor of Pathology, University of Sydney.

The macroscopic changes include slight charring of the muscle in the immediate neighbourhood of the electrode and a much more extensive blanching of the muscle fibres which follows the lines of the muscle bundles (fasciculi) to a considerable distance from the site of the burn. The extent of the actual charring is always limited and slight and is not much different in the different time exposures. But the extent of the blanching which spreads along the muscle bundles is noticeably greater in the longer exposures (*vide* Figures I. and II.).

The microscopic changes include (*i.*) changes in a narrow zone of muscle in the immediate neighbourhood of the burn, (*ii.*) changes in the more remote portions of the muscle fibres, corresponding to the areas of blanching, and (*iii.*) changes in the fibrous and connective tissue that forms the perimysium of the bundles (fasciculi) of the muscle fibres affected.

(*i.*) The parts of the muscle fibres that are close up to the burn have undergone a peculiar form of necrosis. The fibres appear to have undergone partial solution and within the substance of the partially dissolved remains of the fibres there are numerous distended spaces which now appear empty and which probably contained either gas or fluid matter. The general effect is to produce a loose, spongy reticulum in place of the closely grouped lines of muscle fibres.

(*ii.*) The blanched areas which follow the lines of the muscle fibres to a considerable distance from the actual burn show a variety of changes in these fibres. There is an alteration in the staining reaction of some fibres, so that they stain more deeply than the healthy muscle fibres. There are in places foci of partial necrosis of the fibres. But the most usual change is that the fibres have become corrugated throughout their length as far as the blanching extends. This corrugation takes the form of deep and very regular waves, closely resembling those of a corrugated iron sheet. All these changes are present together throughout the blanched area, but are very irregularly distributed throughout the area. These foci of partial necrosis appear at irregular intervals along a muscle bundle (fasciculus). Quite often, too, apparently healthy muscle fibres lie side by side with necrotic or corrugated fibres within the same bundle (fasciculus).

(*iii.*) A very striking change has taken place in the fibrous and connective tissue of the perimysium within the blanched areas. On microscopic section, the perimysium appears as lines of fibrous tissue separating the bundles of muscle fibres, which have all been taken in longitudinal section. Near the burn this fibrous septum has become greatly swollen, homogeneous and deeply staining. Similar changes in the fibrous strands extend throughout the whole extent of the blanched areas, becoming gradually less marked, until they cease near the outer limit of the blanching.

Reports of Cases.

VOLVULUS IN AN INFANT FOUR DAYS OLD.

By **F. C. Burke-Gaffney, M.B.,**
Bendigo.

A patient driving in from the country was delivered of a female child in the buggy and was taken to a hotel a mile away. When I arrived the child was attached to the placenta, which was still *in utero*. The cord was tied and the placenta expressed. The child and patient were removed to a private hospital. The next day the baby was apparently in pain, crying all day. She continued screaming during the next two days and would not take the breast. There was one bowel motion, with no sign of blood or mucus. The following day her temperature was 38.8° C. and she was still screaming, with occasional hiccoughs. The abdomen was not relaxed at any time, so that palpation was unsatisfactory. Nothing abnormal was found on rectal examination. As the infant was obviously very ill, I considered the probability of an intussusception and suggested a laparotomy. After consultation with Dr. H. Jackson, of this city, and Dr. B. W. Cohen, I opened the abdomen through the right rectal sheath, Dr. Cohen giving the anæsthetic. A very injected omentum presented, but the ileo-caecal junction was normal. Further on, however, the small intestine was found twisted on itself and covered with flakes of fibrin. This was straightened out and showed about 7.5 cm. of bowel acutely congested and inflamed, but not yet gangrenous. The peritoneum and posterior sheath of the rectus, both exceedingly thin, were then sutured; the anterior sheath was sutured with plain catgut (No. 1) and the skin with horse-hair. The next day the child's temperature was normal. She had ceased crying and commenced to take her nourishment. Her bowels commenced to move regularly and well. With

the exception of some crossness, due to the extrusion of a catgut knot from the anterior rectal sheath on about the twelfth day, the infant made an uninterrupted recovery and was taken home in the fourth week.

The points of interest are:

1. The difficulty of examination and diagnosis; even under the anæsthetic nothing abnormal could be felt.
2. The evidently continuous pain and increasing illness of the infant.
3. The condition found at operation, *i.e.*, volvulus.
4. The danger of infection of the wound, owing to the very close proximity of a withering and probably highly infective remains of cord.
5. The immediate recovery and apparent absence of shock, despite the bowel manipulation.

The age of the infant—four days—necessitated very careful hæmostasis, as infants so readily succumb to even small losses of blood.

The condition found must have been caused through injury sustained in the hazardous birth, perhaps some violent pull on the cord.

Reviews.

AIDS TO DIAGNOSIS.

Dr. E. P. Minett's "Diagnosis of Bacteria and Blood Parasites"[1] is designed to enable the laboratory worker to identify the more important pathogenic bacteria and protozoa and a few of the ordinary non-pathogenic bacteria and to carry out certain technical operations which fall to the lot of the clinical bacteriologist. We may say at once that this programme has been carried out in a very indifferent manner.

The book is a "cram" book, where all sorts of incomplete clauses take the place of sentences. It teems with errors, both technical and literary, of which the following may serve as examples: On page 15 we find the words: "Stain: Oriental substance, carbolic methylene blue." What is really intended is to "stain the original material with carbolic methylene blue." It seems extraordinary that such an error could still exist in the third edition of any book.

On page 17 it is stated that "litmus milk acid to alkaline = *B. paratayphosus*" and on page 18 that "litmus milk acid only" indicates the "(*a*) variety of *B. paratyphosus*," whereas an "acid reaction slowly progressing to alkaline" is characteristic of "*B. paratyphosus* (*b*)."

On page 20 we read that "Gaertner and allies" give a negative reaction in respect of indol, whereas on page 15 a positive indol reaction is accredited to the same organism.

A very grave error also in the book is the arrangement of the tests. In the early stage of identification to wait for the results of the growth on gelatine in the case of the non-liquefying organisms occasions very slow progress in the working up of the case. The scheme outlined by the author, in which non-liquefaction of the gelatine culture is required as a preliminary test before *B. typhosus* is further identified, however justifiable it may be in systematic works on classification, is impracticable in ordinary laboratory routine.

In connexion with the identification of *B. tetani*, no mention is made of the animal test, *i.e.*, the introduction of the toxic filtrate into one pig and the toxic filtrate together with tetanus antitoxin into another pig; the most reliable positive test in the identification is omitted.

Another extraordinary arrangement in the scheme of identification is that the typhoid-dysentery organisms are not handled as belonging to the same group. The dysentery organisms are dealt with amongst the non-motile bacilli, that is to say, with *B. diphtheriæ*, *B. anthracis*, *B. tuberculosis* and many others, whereas in any practical scheme of work the identification of the dysentery organisms must be taken up with that of the typhoid-coli organisms and worked out chiefly on an agglutination basis. The agglutination basis for the identification of these organisms is practically not dealt with in the book.

In the description of *B. influenzæ* no mention is made of filamentous forms, references to which are extremely frequent in the literature.

On page 31 we read that, as evidence of a positive mallein reaction, a rise of temperature of 1.5° may be taken; but no mention is made of the scale used.

The identification of the pseudo-tuberculosis bacillus, dealt with on page 34, is entirely inadequate. The real difficulty in identifying this bacillus does not consist in distinguishing it from the bacillus of ordinary tuberculosis, but from the plague bacillus. This difficulty is not dealt with.

It is regrettable that in the section dealing with staining the iron-hæmatoxylin method is not mentioned, though it is usually employed as the final test in the identification of many of the protozoa.

The description of the Wassermann test is so inadequate as to be misleading.

On page 56 crowded colonies are spoken of as "thick" colonies.

In the section dealing with the counting of bacteria, Wright's method of counting against red corpuscles is the only one given, although it is entirely out of date. The dark ground method is much more accurate and the opacity method much easier, but neither is mentioned.

In the making of blood cultures from the human subject, no mention is made of the need for bile in the broth if we would cultivate *B. typhosus* and allied species from the blood.

[1] Diagnosis of Bacteria and Blood Parasites, by E. P. Minett, M.D., D.P.H., D.T.M. & H., M.R.C.S., L.R.C.P., Government Medical Officer for Health, British Guiana, formerly Assistant Bacteriologist, Guy's Hospital, London, S.E.; Third Edition; 1920. London: Baillière, Tindall & Cox; Demy 8vo., pp. 94.

AMERICAN UNIVERSITIES.

Professor E. R. Holme, of Sydney, has made a personal, if somewhat hurried, study of American universities and presents a concise account of the impressions he has received, with criticisms, both of the American type and incidentally of our own universities and those of Great Britain.[1] He maintains that the American university is typical and that the type is fixed, whether the university be endowed or State. One of the most characteristic features of the type is the position and power of the president. Professor Holme, in common with many members of the professoriate, objects to the office of president. He says: "However the situation is modified by good presidents, good governing bodies, good university traditions and outside influences, it is not good in itself. The very idea of a university is obscured and may be falsified by it." Again: "I am quite satisfied that the American presidency ought not to be imported into any Australian university," although he admits that "the addition of a president might be the cause of temporary progress, even in the learning and teaching values of the university." Professor Holme is further of opinion that, partly as a result of the presidential system, there is too much administrative machinery in American universities. On the other hand, he realizes that in Australian universities too much administrative work devolves on the professors and suggests that sub-deans of faculties might be appointed on the American plan and that both deans and professors ought to have more clerical assistance.

Another characteristic of American universities is the attention given to graduate work, while the college or undergraduate course includes a great amount of elementary work done in schools in Australia and Great Britain. American universities have no honours system. "The American method is traditionally directed towards movement in common, over a wide field, at a good average rate. The quick are left to stimulate the slow and no competition for individual distinction is encouraged."

Among other subjects dealt with are "the dormitory," the American term for a residential non-tutorial college, and university extension, "the vast development of which in America is a commonplace."

Concerning the university and the community, Professor Holme observes: "A vast and beneficent influence in American society is the American university. The support that it has from its graduates and the community proceeds from a just regard and is but a sign of mutual service in a noble tradition of the American nation."

[1] The American Universities: An Australian View, by Professor E. Holme; 1920. Sydney: Angus & Robertson, Limited; Crown 8vo., pp. 242. Price, 7s. 6d.

The Medical Journal of Australia.

SATURDAY, APRIL 2, 1921.

Food Preparations and Proprietary Remedies.

In his thoughtful and suggestive presidential address, Dr. C. Bickerton Blackburn, O.B.E., the retiring President of the New South Wales Branch of the British Medical Association, complains that medical practitioners frequently prescribe food preparations and proprietary remedies without being aware of the constituents. He blames his colleagues for accepting with blind faith the advertised claims of the manufacturers and he chides the manufacturers for the extravagance of the claims advertised for their preparations. This warning is timely and justified. It is well known that the public will believe any fairy tale printed in connexion with a patent medicine. It would seem that even the medical profession does not exercise sufficient discrimination in judging proprietary preparations. Dr. Blackburn referred to the measures adopted in Great Britain and in the United States of America for the control of products of this kind advertised in the leading medical journals. He announced that an analytical department was being introduced in the organization of this *Journal*.

Hitherto a strict control has been kept over the claims made in the advertisements appearing in *The Medical Journal of Australia* in regard to proprietary preparations and foods. In no case has an advertisement been accepted without preliminary inquiries concerning the composition of the articles to be advertised. This control, however, has been insufficient. It is now proposed to carry out an inspection of the processes of manufacture of all foods and proprietary remedies prepared in Australia which are offered for advertisement. The articles will be analysed by expert chemists and precautions will be taken to ascertain whether the articles sold in the open market correspond to the samples proffered for analysis. Standards of food preparations are being set up. All food preparations that do not conform to these standards will be excluded from our advertisement pages. The results of the inspection and of the analyses will be published editorially in order that our readers may be informed concerning the reliability or otherwise of the Australian-made food preparations. In regard to proprietary remedies, an inspection will be undertaken for the purpose of ascertaining whether sufficient care and cleanliness are observed in the compounding of these preparations. The inspectors will not inquire into the trade secrets. On the other hand, the finished product will be subjected to analysis and the constituents will be evaluated from the point of view of pharmacological and therapeutical knowledge. A preparation which is found to contain no constituent or constituents possessing the pharmacological action claimed for the preparation, will be excluded from our pages. Moreover, the publication in another journal or newspaper of untenable claims for a proprietary remedy will disqualify it for acceptance among our advertisements. Those who will carry out the tasks of inspection and analysis, will exercise judgement and fairness, so that no unjust or arbitrary decision is reached. A manufacturer who is not prepared to submit his goods to inspection and analysis, will not be permitted to enjoy the privilege of having an advertisement in *The Medical Journal of Australia*. The inspection and analysis will be undertaken in all cases without obligation on the part of the manufacturer to advertise in the *Journal*, but he will be required to consent to the publication of the inspector's and analyst's reports whether they prove favourable or unfavourable. We shall be liable only if the reports published contain untrue statements.

In view of the impossibility of extending this programme to food preparations and proprietary remedies manufactured outside Australia, it has been determined to waive the necessity of inspection and analysis in the case of articles advertised in the *British Medical Journal*. It is, however, of importance for our readers to note that the partial guarantee attaching to the acceptance of a food preparation or proprietary remedy after inspection and analysis is not extended to the overseas products. The acceptance of the latter implies that the *British Medical Journal* is satisfied that the claims made for the particular preparations are reasonable.

This programme is being introduced at considerable cost, after the expenditure of much thought and care. It may result in the withdrawal of business, which means financial loss. Manufacturers of pure and sound articles will no doubt recognize the immense advantage which admission to our advertising pages will bring to them. It is not likely that many will refuse to pay the enhanced charges. Our aim is to guide the members of the medical profession in selecting food preparations and proprietary remedies for use in their practices. It will still be necessary for each medical practitioner to make careful, accurate and prolonged observations of the effect of these compounds on their patients. The public should derive benefit from this differentiation of the good from the bad. Incidentally we hope to bring much benefit to the manufacturer who serves the public and the medical profession honestly and well.

UTERINE CURETTAGE.

The uterine curette, devised by Marion Sims more than half a century ago, has been described as the most popular of all surgical instruments. In the experience of every general practitioner curettage of the uterus is certainly a very common expedient in the treatment of gynæcological diseases. It is an operation which retains its popularity in spite of the most trenchant criticism by men of good judgement and ripe experience. The instrument and the use of the instrument received the full shock of disapproval by eminent gynæcologists at its first introduction by its inventor, no less an authority than Dr. T. A. Emmet remarking that the ingenuity of man had never devised an instrument capable of doing more injury. The uterine curette survived that onslaught and fast gathered in its disciples. Of recent years a more determined and strategic attack has been made. Drs. A. Heineberg, J. O. Polak, W. A. Lincoln and J. Wesley Bovée have within the last year or two condemned uterine curettage as practised by the majority of members of the profession. Dr. Bovée[1] speaks without mincing his words. He recalls "with deep humiliation" the practice of curetting for indications in his opinion long since discredited and he makes the accusation that the "most slovenly and ignorant physician" resorts unhesitatingly to the curette for real and imaginary diseases of the uterus and even of the appendages. Drs. Heineberg and Bovée decry the generally accepted practice of curetting for incomplete abortion and as a procedure preliminary to plastic operations on the vagina and abdominal sections. All condemn the operation for the treatment of endometritis, which is gravely suspected of being more a figment of the imagination than a definite pathological process. The work of Dr. Arthur H. Curtis is frequently quoted to prove that endometritis in its strict sense does not exist, apart from infection of the uterine adnexa and that the scraping away of an inflamed endometrium cannot be described as the cure of the condition when the associated lesions remain untreated.

These reactionary opinions, when contrasted with the more conservative teaching on the subject, tend to confuse the attitude of the practitioner whose views have not been firmly implanted in the soil of a wide experience. With a view to restoring the balance, Professor W. E. Fothergill, of Manchester University, has written an admirable article[2] on the dangers and proven advantages of the curette. The dangers are the carriage of infection into the uterus, laceration of the cervix from hasty or unskilful dilatation and perforation of the body. The latter mishap is a much more common occurrence than is generally supposed, but the tear is usually closed over by the contraction of the uterine musculature and in the absence of infection, no untoward result occurs.

Dr. Fothergill claims that curettage has an established value in infection of the womb after birth or miscarriage, provided the infective organisms have not entered the dilated uterine sinuses. He deprecates the attack made on the operation, because the patient dies if the organisms enter the blood stream, a *dénouement* uninfluenced by the surgical treatment. For the removal of retained products of conception after incomplete abortion, he considers that the operation has survived all criticism. This appears to be sound common sense and the opponents of the operation have adduced no evidence to show that retained secundines are best left alone. Dr. Fothergill disdains to argue about what he considers an established principle, but it may be mentioned that, apart from the danger of infection, there is the risk of secondary anæmia following hæmorrhage with all its attendant manifestations of ill-health.

The Professor is no blind devotee of the curette. He decries its use in leucorrhœa which is caused by excessive secretion from the glands of the vagina and occasionally the cervix and is quite independent of the *corpus uteri*, in spasmodic dysmenorrhœa which is relieved by simple dilatation of the cervix, and in congestive dysmenorrhœa which is due to the dull aching of distended veins in the pelvis and has its analogue in the varicocele of the male. In menorrhagia the rule should be never to curette, in metrorrhagia always; the reason of this is that excessive hæmorrhage during the menstrual period is due to the excessive hormonic secretion of the ovary or to some pathological cause, such as a primary anæmia, whereas hæmorrhage between the periods may well be caused by some intra-uterine abnormality, such as cancer of the uterus or a submucous fibroid. The value of curettage in cases of uterine hæmorrhage following the menopause can only be denied by those deprived of the gift of imagination, for the curette represents our best means of diagnosing the beginnings of cancer of the uterus at the most insidious stage of its development from the comparatively harmless post-menopausal endometritis.

[1] *Surgery, Gynecology and Obstetrics*, June, 1920.

[2] *The Lancet*, January 8, 1921.

Curettage for sterility is irrational in the absence of a preliminary examination of the husband, but experience has shown that it is not unusual for a sterile woman to become pregnant after this operation when no definite cause for her sterility has been discoverable.

The last word has not yet been heard on the subject, but it may be confidently anticipated that in spite of those partisans who condemn it utterly and those who with little sense or reason practice it with no relation to the indications for its use, the operation of uterine curettage will survive as one of the best means for good at the discretion of the gynæcologist.

THE ÆTIOLOGICAL RELATIONSHIP BETWEEN GENERAL PARALYSIS AND MULTIPLE SCLEROSIS.

It is several years now since Noguchi did much to elucidate the histo-pathology of *dementia paralytica* by his discovery of the *Spirochæta pallida* in the cerebral cortex of patients who had succumbed to the disease. Levaditi, Marie and Bankowski added to this valuable discovery the proof that it was impossible with our present means of investigation to demonstrate the presence of the organism outside the cortex. They also pointed out that it was discoverable only in certain circumscribed areas of the grey matter. Further, the organism was only isolated when the patient had recently been suffering from paroxysms or acute exacerbations of the disease. Dr. G. Schuster has recently pointed out[1] that in cases of general paralysis the spirochætes are congregated chiefly in the lower cortical strata. In many instances they were found in large numbers in the border zone of cortex and medulla, while the degenerative forms were present chiefly in the upper cortical layers. He also demonstrated the presence of spirochætes in the cortex of patients who showed no clinical evidence of paroxysms of the disease. In one case of disseminated sclerosis he discovered fine spirochætes, indistinguishable from the *Spirochæta pallida*, in the upper strata of the cortex. Dr. Schuster draws a comparison between this disease and general paralysis. The patches of sclerosis in the former are frequently more or less confined to the cortico-medullary boundary, which would appear to have some obscure micro-chemical affinity for the causative agent of both diseases. In disseminated sclerosis there is a plexiform disintegration of the myelin sheath of the nerve fibres and a similar histological change has been frequently observed in cases of general paralysis. Further, in the latter disease the disintegration occurs at the boundary of cortex and medulla. Lastly, a similar curve is obtained from Lange's colloidal gold reaction in disseminated sclerosis, general paralysis and cerebral syphilis.

These observations may be found to be of importance in the elucidation of the ætiology of multiple sclerosis. They are of further interest in focusing our attention on that interesting anatomical zone which lies between the grey and the white matter of the cerebrum.

[1] *Lancet*, January 1, 1921.

MEDICAL INFORMATION IN THE LAY PRESS.

The daily newspaper exists for two purposes. It conveys news to the people of the contemporary happenings in all parts of the world. It also has unique opportunities for educating the people. The third use to which the newspaper is put, need not detain us, for its value to the majority of people is questionable. It is the expression of political views. It is regrettable that the chronicle of the world's events as recorded in our morning and evening papers is not always reliable. People who believe all they read in the daily press, are apt to be grossly misled. In regard to the second function, the readers of the newspapers are served with a strange perversion of scientific facts. In some instances the information is merely altered for the purpose of popularization. In medical science, however, the Australian newspapers have an unhappy knack of admitting the most surprising and stupid inaccuracies. The worst offenders are the evening newspapers. Recently a Sydney evening publication gave prominence to an alleged recent addition to our knowledge concerning three worm infestations. Had the cable been properly evaluated, the correspondent responsible for its transmission should have been dismissed. To make matters worse, there was attached to the cabled "news" a strange pseudo-scientific explanation, full of incorrect statements. In the first place, tartar emetic was employed in experimental work in the protozoal infections 18 years ago by Plimmer and Thompson with good results. Later the suggestion was made that this well-known drug might be of use in bilharziosis. Christopherson was the first to apply it in human infections and published his results in 1918. This treatment is recognized as better than any other and has been adopted in Australia and elsewhere for a considerable time. In the next place anchylostomiasis has long since been counted among the curable affections. The International Health Board of the Rockefeller Foundation selected anchylostomiasis or hookworm infestation because the presence of the worm could be detected with ease and the cure demonstrated to the sufferers. The oil of chenopodium has been used in this connexion for at least five years. Neither is there any justification in the claim that *Hymenolepis nana*, the dwarf tapeworm, has defied treatment up to the present time. The treatment of the tapeworms has been very satisfactory for many years. It is quite untrue that this worm has only been found once in man in Australia. Breinl found it frequently among the Italians in Townsville, while Waite reported in 1918 no less than 51 persons carrying this worm among those examined for hookworm. It is probably not an uncommon infestation in many parts of the Commonwealth. It thus appears that nearly all the statements contained in the paragraph to which we have referred, are incorrect. Moreover, this annotation is by no means exceptional. The daily press is not fulfilling its functions in regard to the education of its readers. The fault lies in the neglect on the part of the management of the papers to employ competent medical correspondents to control the rash messages cabled from the other side and to compile reliable commentaries to any real medical information.

Abstracts from Current Medical Literature.

SURGERY.

(118) Hypophyseal Duct Tumours.

William C. Duffy (*Annals of Surg.*, November, 1920) reports three cases of squamous epithelial tumour of the hypophyseal region and a cyst of Rathke's pouch. Squamous epitheliomata in this situation are very rare. They range in structure from simple cysts lined with squamous epithelium to tumours often reported as teratomata. The first case was an intra-cystic squamous epithelial papilloma, arising from a rest of the hypophyseal duct in the anterior lobe. There was enlargement of the *sella turcica* with symptoms which included headache and visual disturbances. The cyst was evacuated, but injury to the internal carotid resulted in death 12 days later. The second case was a cystic supra-sellar tumour with adamantinoma characters, developing from an infundibular squamous epithelial rest in a child of eleven. Here also death followed evacuation of the cyst.

(119) Diverticulitis of the Colon.

R. P. Rowlands (*Clin. Journ.*, December 8, 1920) records 6 cases of diverticulitis of the large bowel and points out that the condition is often mistaken for malignant disease, especially of the sigmoid colon. The protracted history and the absence of blood from the stools after repeated examinations will assist in the differentiation. Diverticula are easy to overlook, especially if they are situated near the mesenteric border. They may lead to inflammation, abscess, perforation and local or general peritonitis. Chronic inflammation may lead to thickening and shortening of the mesentery with secondary stenosis. The formation of diverticula seems associated with long-standing constipation and the symptoms seldom arise before middle age. It is advisable to operate without waiting for obstruction and resection with end-to-end anastomosis seems to be the operation of choice.

(120) Gastric Ulcer.

J. Sherren (*Clin. Journ.*, December 8, 1920) considers that clinical evidence supports Bolton's experimental work in favour of attributing gastric ulcers to infection, and their failure to heal to hyperacidity or gastric stasis. Hurst's investigations with the aid of X-rays have shown why one patient gets a gastric and another a duodenal ulcer. There are two types of stomach—hypertonic and hypotonic. The former empties rapidly, is associated with hyperacidity and occurs in men particularly. Duodenal ulcer occurs in this type. The hypotonic stomach empties slowly and is associated with ulcer of the lesser curvature. About 60% of acute ulcers are multiple and are usually situated near the lesser curvature. Chronic ulcer is single and is usually 2.5 to 3.7 cm. in diameter. If it is larger the presence of malignancy should be suspected. The initial lesion in acute ulcer is generally necrosis of the mucous membrane, but it may also be inflammation of a lymphoid follicle or hæmorrhage into the mucous membrane.

(121) Cholecyst-gastrostomy.

Charles S. White (*Surg., Gynec. and Obstet.*, November, 1920) maintains that cholecyst-gastrostomy has a definite place in surgery. It is indicated in cases of inoperable obstruction of the common duct or after division of the duct, when there is no hope of suture. For long-continued drainage in infective biliary cirrhosis it is superior to cholecystostomy in that nutrition can be maintained. It is not difficult to perform and is safer than an anastomosis between the gall bladder and small intestine, since there is no danger of ascending infection. The presence of bile in the stomach is consistent with good digestion. The suture method is the only one to employ.

(122) Cancer of the Rectum.

Ernest A. Wells (*Surg., Gynec. and Obstet.*, November, 1920) publishes his experience of 53 cases of cancer of the rectum. He finds no causal relationship with syphilis and advocates the uses of the cystoscope for examination of the growth. For cystoscopy the patient should lie in the knee-chest position and the rectum should be filled with water. He insists on the slow course of many cancers in this situation. Pain and blood in the stools were outstanding features in his cases. He believes in colostomy for hopeless cases, because it relieves the obstruction and lessens the chronic poisoning. A plea is made for early and radical surgery.

(123) Carcinoma of the Duodenum.

McGuire and Cornish (*Annals of Surg.*, November, 1920) emphasize the rarity of carcinoma of the small intestine. Inch for inch in the small intestine, the site of election seems to be the duodenum. The great majority occur in the second part, but in this position carcinoma of the ampulla is hard to exclude at autopsy or operation. The first part of the duodenum is affected somewhat more often than the third. The growth is usually a cylindrical-celled adeno-carcinoma. Lichty has reported six cases of the first part, none of them at the site common to ulcer, and he claims that the ratio of carcinoma due to ulcer in the duodenum is as one to eighty, whereas in the stomach it is as one to two and a quarter. The authors report four cases, two of which were probably primary carcinoma of the common bile duct, with secondary duodenal involvement.

(124) Spermatocele.

E. Crossan (*Annals of Surg.*, October, 1920) defines spermatocele as a" retention cyst of the scrotum which is, or has been, in communication with the semen-carrying system." Various theories are discussed, from Liston's (dilated seminal tubules theory) to Virchow's (retention cyst theory), which is now the accepted one. Their causation has been attributed to trauma (laceration of *vasa efferentia*), sexual abstemiousness and gonorrhœa. The last two suggested causes are without clinical support. Two types are recognized—the extra-vaginal, arising from the *vas aberrans superior* and the *vasa efferentia* and the intra-vaginal, springing from the sessile hydatid or the canal of the epididymis. The walls of a spermatocele are composed of interwoven connective tissue strands with some smooth muscle fibres and the contents are usually milky or soapy in appearance.

(125) Treatment of Ruptured Pyloric Ulcer.

R. Lewisohn (*Surg., Gynec. and Obstet.*, November, 1920) maintains that simple suture of an acutely perforated pyloric or duodenal ulcer will not, in a considerable number of cases, cure the ulcer. Immediate gastro-enterostomy is necessary and does not increase the mortality rate. It also guarantees proper drainage of the stomach contents and overcomes the partial pyloric obstruction caused by the subsequent pyloric adhesions. Pyloric exclusion is also recommended. Simple suture is reserved for those patients who are grave operation risks.

(126) Cholecystectomy.

Moses Behrend (*Journ. Amer. Med. Assoc.*, July 24, 1920) describes what he claims to be an improved technique for cholecystectomy. He attributes the trouble in ordinary cholecystectomy to the use of the "closed" method, *i.e.*, the operation is performed within the gastro-hepatic omentum. An air cushion is employed and an oblique paramedian incision is made. Traction is made on the gastro-hepatic and gastro-colic omenta in opposite directions and the right free border of the gastro-hepatic omentum opened and the ducts and blood vessels exposed to view. The gall bladder is removed from below upwards and a tube left in for two or three days. The danger of ligaturing the hepatic artery in the ordinary operation is insisted on.

(127) Sarcoma of the Stomach.

W. D. Haggard (*Surg., Gynec. and Obstet.*, November, 1920) records a case of sarcoma of the stomach and analyses 107 similar cases in patients who came to operation or underwent *post mortem* examination. The condition may occur at any age and the tumour's size varies from that of a bird's egg to that of a growth filling the abdomen. It may, according to its cell origin, be a leio-, fibro- or lympho-sarcoma or an endothelioma. It is said to have metastases in 40% of its cases, but in this respect is not nearly as malignant as carcinoma. It is prone to have metastases in skin and perforation is apt to occur. Diagnosis is often impossible; there may be no gastric symptoms whatever. The dyspeptic history is seldom a long one. Pain is early and persistent

GYNÆCOLOGY AND OBSTETRICS.

(128) Pregnancy and Latent Syphilis.

R. A. Hendry (*Lancet*, November 13, 1920) investigated the subject of latent syphilis in pregnancy. He examined patients and collected information at the Liverpool ante-natal clinics. By latent syphilis he means that form of the disease in which, apart from the effect on the pregnancy, there are no active symptoms or signs. He thus excludes primary and secondary syphilis. He sought evidence from both clinical and laboratory investigations, which included the history of infection and the past obstetrical history, together with the Wassermann reaction and the examination of still births, abortions and placentæ. He concludes from a review of 94 cases: (1) that the clinical evidence (including the obstetrical history of abortions and still births) of syphilis is unreliable; (2) that the Wassermann reaction is the test by which, at present, the diagnosis must usually be made; it must be borne in mind that the so-called "negative" or "slightly positive" reaction may occur in syphilis during pregnancy and, moreover, that a "positive" reaction may occur in a non-syphilitic individual; (3) that the examination of still births, etc., furnishes reliable but at present insufficiently available evidence; (4) that the institution of mercurial treatment before pregnancy occurs justifies a favourable fœtal prognosis; and (5) that the prognosis when treatment is begun during pregnancy depends on the unknown and already present degree of infection of the fœtus. In reviewing the above, Amand Routh considered that the above facts helped to elucidate the many doubtful problems of the subject, such as the causes of the latency of the infection, the anomalies and irregularities of the Wassermann reaction in both mother and child and the best methods to be followed in treating both mother and child during and after pregnancy, so as to cure the mother and prevent congenital syphilis in the child. He referred to "spirillolysis," which means the breaking up of the mature spirochæte under various influences into "granules" from which spiral forms may again sprout. It is probable that this occurs during pregnancy under the influence of the chorionic ferments in the mother and that these granules remain "latent," so that they do not sprout or multiply in the tissues of the mother or fœtus as long as the chorionic ferments are present, but that after pregnancy, when the ferments have disappeared, the granules become active and the mature organisms develope. Paternal infection may be conveyed by granules in the spermatozoa or in the seminal fluid, and these are kept latent in the same way. If the mature organism were conveyed by the semen, it would be promptly granulated in similar fashion. He regards the treatment of the pregnant mother, which has in view the cure of the mother and the prevention of congenital syphilis in the child, as only likely to be successful if, up to the date of its commencement, the multiplication of the mature spirochæte has been prevented by the granulating and inhibiting action of the ferments, for, if the unrestricted infection by the mature organism had been going on in the early cellular ovum or fœtus, the latter would have been speedily destroyed, since every growing organ would have been invaded. The treatment, therefore, should be adopted at the earliest possible moment and continued after birth. He believes that congenital syphilis could be prevented if every expectant mother came under scientific medical supervision and if facilities for diagnosis and for both efficient and sufficiently prolonged treatment of mother and child were available. McDonagh said that once a woman was syphilitic she required treatment throughout each succeeding pregnancy, even if the husband of a second or further marriage had never had syphilis. He always treated the children as syphilitic, as he had seen many in whom symptoms of *syphilis congenita tarda* developed.

(129) Transition from Benign to Malignant Conditions.

T. W. Eden and G. Ley (*Amer. Jour. of Obstet and Gynec.*, October, 1920), writing on the subject of "precancerous" conditions of the female reproductive organs, state that the transition from benign to malignant histological characters is so gradual that it is very difficult to define a stage that is "precancerous." All ovarian neoplasms should be removed, as there is clear evidence that cancer grows as a rule in an ovarian cyst, not in an unaltered ovary. Benign adenomata of the *corpus uteri* which show abundant atypical proliferation of the gland tubules and their epithelium, are to be regarded as precancerous and call for pan-hysterectomy. In the cervix erosions may heal, but may become the seat of a squamous-celled epithelioma. Old-standing cervical lacerations with thickened and everted erosions should be regarded as precancerous and be freely excised. Cervical adenomatous polypi may become malignant and should be removed. Chronic vulvitis is generally speaking, not precancerous. A leukoplakia accompanied by enlargement of the inguinal glands, is precancerous and should be treated by free excision of the vulva and glands. The authors suggest that glycosuric vulvitis is specially prone to be followed by cancer. Gonorrhœal warts do not become malignant.

(130) The Pathology of Utero-Placental Hæmorrhage.

Gordon Ley (*Proc. Roy. Soc. Med.*, December, 1920), after reviewing the literature on the pathology of uteroplacental (accidental) hæmorrhage and describing his own work on a series of specimens, concluded that the changes characteristic of and peculiar to cases of accidental hæmorrhage are wide-spread necrosis, hæmorrhage and œdema in the myometrium. These changes are not due to mechanical injury. The necrosis is closely associated with, but is not caused by the hæmorrhages. The necrosis, hæmorrhage and œdema are due to the same cause. The cause is a toxæmia of pregnancy, which damages the kidneys and liver as well as the uterus. A less degree of this toxæmia may cause necrosis of the myometrium without hæmorrhage and œdema. A still less degree may cause slight necrosis without hæmorrhage and œdema and without albuminuria, which is evidence of poisoning of the kidney. The necrosis of the myometrium renders the uterus liable to rupture. In the wombs affected by this necrosis the evidence of fatty degeneration is extremely slight and is no greater than that in a normal uterus at full time. In the discussion Eden stated that it is now possible to distinguish three types of pregnancy toxæmia—one associated with pernicious vomiting, one with eclampsia and one with accidental hæmorrhage. The clinical features are widely divergent and it can hardly be thought that the toxins are the same in each type. Spencer pointed out that in a large proportion of cases there is no albuminuria and that even in the severest cases there may be an absence of albumin. Briggs referred to recent work done by Roberts in Liverpool, who, in an analysis of 32 severe cases with a maternal death-rate of 6.08% and a fœtal death-rate of 94%, stated that in only 29% was there albuminuria. Hence, as a direct cause of accidental hæmorrhage, the ordinary toxæmia of pregnancy may be almost ruled out. The toxæmia, if any, may be of a special kind. Ley, in reply, gave the sequence of events as necrosis of muscle, consequent hæmorrhage, tracking of the blood through the decidua, thus separating an area of the placenta, opening of the uterine sinuses and, finally, the hæmorrhage. In his own 50 cases 84% were associated with albuminuria and he considered the smaller percentages recorded by other observers to be due to the inclusion of cases of lateral *placenta prævia* in the figures for accidental hæmorrhage.

(131) The Non-Operative Determination of Patency of Fallopian Tubes.

I. C. Rubin (*Jour. Amer. Med. Assoc.*, September 4, 1920) has utilized intrauterine inflation with oxygen and the production of an artificial pneumoperitoneum to determine the patency of the Fallopian tubes. An accurate knowledge of the anatomical patency of the tubes is important in deciding upon the prognosis and therapy of female sterility, as with closed tubes operations on the cervix, curetting, gland therapy, etc., are obviously useless. He describes the technique of the operation and states that 150 c.cm. of oxygen is usually sufficient. When the tubes are patent the pressure of the inflating gas need not exceed 40 mm.. A pressure of 200 mm. is certain to be due to closed tubes. Fluoroscopy is employed to check the result in cases advise the method in acute inflammatory conditions.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the New South Wales Branch was held at the B.M.A. Buildings, 30-34 Elizabeth Street, Sydney, on March 18, 1921, Dr. C. Bickerton Blackburn, O.B.E., the President, in the chair.

Annual Report.

The annual report of the Council was presented by the Honorary Secretary and received. The text of the report is as follows:

The Council presents the following report upon the work of the Branch for the year ended March 18, 1921:

Membership.—The membership of the Branch is now 1,180, as compared with 1,200 at the date of the last Annual Report, showing a net decearse of 20. The additions have included figures as follows: Elections and resumption of membership, 78; removals into the area of the Branch, 29. The losses have included: Resignations, 23; removals out of the area of the Branch, 35; default in payment of subscription, 49; deaths, 12. The losses by death have been as follows: Dr. W. H. Low, Dr. T. Thomson, Dr. A. E. Salter, Dr. C. Ayres, Dr. S. A. Alcorn, Dr. Neville Griffiths, Dr. S. W. Morton, Dr. L. Herschel Harris, Dr. J. A. Beattie, Dr. F. H. May, Dr. C. J. Tozer, D.S.O., Dr. the Honourable J. L. Beeston, M.L.C., C.M.G., V.D..

Meetings.—Nine ordinary meetings of the Branch, including the annual general meeting, six extraordinary meetings and eight clinical meetings were held. The average attendance was 53. Clinical meetings were held at the Royal Alexandra Hospital for Children, Royal Prince Alfred Hospital, the Sydney Hospital, the Blackfriars Practice School, the New South Wales Institution for the Deaf and Dumb and the Blind and the Mental Hospital, Callan Park. The ordinary meeting of April 30, 1920, was held at the Chamber of Commerce, Newcastle, when the visiting members were entertained by the members of the Central Northern Medical Association. The business of the ordinary and clinical meetings included 22 papers and addresses and numerous reports of cases, demonstrations and exhibits, as well as lantern demonstrations. Owing to the meeting of the Australasian Medical Congress in Brisbane, August 23-28, 1920, the ordinary meeting of August 24 was not held.

Representation.—The Branch was represented as follows:

(*a*) Council of the British Medical Association: Dr. H. A. Francis (London).
(*b*) Representative Body: Dr. F. Antill Pockley.
(*c*) The Federal Committee of the British Medical Association in Australia: For the year 1920, Dr. R. H. Todd and Dr. F. P. Sandes (Dr. T. W. Lipscomb, substitute for Dr. F. P. Sandes at the Federal Committee Meeting of August 25, 1920). For the year 1921: Dr. R. H. Todd and Dr. J. A. Dick, C.M.G..
(*d*) Australasian Medical Publishing Company, Limited: Dr. W. H. Crago, Dr. F. P. Sandes, Dr. R. H. Todd.
(*e*) Council of the New South Wales Bush Nursing Association: Dr. C. B. Blackburn, O.B.E..
(*f*) Repatriation Department Vocational and Training Committee: Dr. R. Gordon Craig and Dr. R. H. Todd.

Council.—The attendance of members of the Council and of the Standing Committees of the Council was as set out in the table below.

The Representatives of the Local Associations of Members appointed on the invitation of the Council to attend the regular quarterly meetings of the Council were as follows: Dr. W. A. H. Burkitt (Central Southern), Dr. E. C. Hall (Central Western), Dr. A. M. Gledden (City), Dr. F. G. N. Stephens (Eastern Suburbs), Dr. F. O. Stokes (Eastern District), Dr. W. F. Simmons (Illawarra Suburbs), Dr. W. B. Dight (Northern District), Dr. E. A. R. Bligh (Northern Suburbs), Dr. R. I. Furber (South Sydney), Dr. E. Tudor Jones (Western Suburbs), Dr. E. H. Burkitt (Western).

B.M.A. Building.—Dr. W. H. Crago continued his services as "Premises Attorney" and gave the same assiduous attention to the important work connected with his office as he has done during the last ten years.

The Library.—Dr. J. A. Dick was re-appointed to the office of Honorary Librarian, which he has held for many years.

Donations of books, journals and documents were received from the Australasian Medical Publishing Company, Limited, Dr. E. H. Thane, Dr. R. Worrall, the Victorian Branch and Dr. J. W. Bean.

Affiliated Local Associations of Members.—The following is a list of the Affiliated Local Associations of Members, with the names of their Honorary Secretaries: Balmain District (Dr. W. B. Grant), Border (Dr. R. A. Robertson), Central Northern (Dr. H. G. Allen), Central Southern (Dr. G. A. Buchanan), Central Western (Dr. K. S. Macarthur Brown), City (Dr. H. A. Ridler), Eastern District (Dr. P. S. Parkinson), Eastern Suburbs (Dr. W. Evans), Illawarra Suburbs

	Council.	Executive and Finance Committee.	Ethics Committee.	Organization and Science Committee.	Medical Politics Committee.	*Medical Journal* Sub-Committee (Exec. and Finance Committee).
	(8)	(14)	(11)	(9)	(12)	(11)
Dr. George Armstrong	6	12	—	—	—	8
Dr. F. Barrington	6	9	8	1	10	—
Dr. C. B. Blackburn (President)	6	12	4	1	11	7
Dr. A. J. Brady	6	—	10	—	—	—
Dr. W. H. Crago (Honorary Treasurer; Premises Attorney)	6	12	6	2	6	10
Dr. F. Brown Craig	5	—	—	9	—	—
Dr. A. Davidson	7	—	9	—	—	—
Dr. J. Adam Dick (Honorary Librarian)	7	11	—	—	10	—
Dr. Sinclair Gillies	3	—	7	—	—	—
Dr. Sydney Jamieson	5	11	—	—	—	—
Dr. C. H. E. Lawes	6	—	—	—	8	—
Dr. T. W. Lipscomb	7	—	—	—	11	—
Dr. W. F. Litchfield (Honorary Medical Secretary)	5	—	—	9	—	—
Dr. A. A. Palmer (1)	4	—	8	—	—	—
Dr. Clarence Read	7	—	—	—	5	—
Dr. F. P. Sandes (Ex-President)	7	8	—	3	—	5
Dr. S. A. Smith (3)	3	—	—	—	7	—
Dr. D. Thomas	4	9	—	—	—	—
Dr. R. H. Todd (Honorary Secretary) (2)	6	12	10	6	10	10
Dr. R. B. Wade	5	—	10	6	—	—

(1) Absent on leave, January to May, 1920.
(2) Absent on leave, April to June, 1920.
(3) Absent part of year, Technical Commission of Inquiry, Broken Hill.

(Dr. W. F. Simmons), North Eastern (Dr. R. V. Graham), Northern District (Dr. E. W. Buckley), Northern Suburbs (Dr. F. Guy Griffiths), South Eastern (Dr. H. H. Lee), Southern District (Dr. S. H. Weedon), South Sydney (Dr. J. G. W. Hill), Western Suburbs (Dr. J. F. Walton), Western (Dr. J. T. Paton).

Annual Meeting of the Delegates of the Local Associations with the Council.—The ninth annual meeting of the delegates of the Affiliated Local Associations with the Council was held on October 1, 1920, at the B.M.A. Library, Sydney, and the proceedings of the meeting were published in *The Medical Journal of Australia*, 1920, Vol. II., p. 403. The delegates were as follows: Dr. C. U. Carruthers (Balmain District), Dr. R. A. Robertson (Border), Dr. N. J. Dunlop (Central Northern), Dr. G. A. Buchanan (Central Southern), Dr. K. S. M. Brown (Central Western), Dr. A. M. Gledden (City), Dr. F. O. Stokes (Eastern District), Dr. F. G. N. Stephens (Eastern Suburbs), Dr. W. J. White (Illawarra Suburbs), Dr. T. J. Henry (North Eastern), Dr. W. E. Harris (Northern District), Dr. F. Guy Griffiths (Northern Suburbs), Dr. W. W. Martin (Southern District), Dr. J. Hoets (South Sydney), Dr. F. C. Rogers (Western Suburbs), Dr. L. W. Roberts (Western).

"The Medical Journal of Australia."—The Directors of the Australasian Medical Publishing Company, Limited, and the Editor are to be congratulated upon their work for the past year, especially in view of the enormous increase in the cost of producing the *Journal*. In the circumstances, it is not surprising that the Company has not found it possible to make any distribution to the Branches.

Contract Practice.—(*a*) Friendly Society Lodges.—(1) Amendment of the Common Form of Agreement. In July, 1920, the Friendly Societies' Chief Secretaries' Association approached the Council with a request that the Approved Common Form of Agreement between medical officer and friendly society lodge be amended to provide that the income limits (£208 and £312), which hitherto have determined the right of lodge members to receive the medical benefit, should be increased to £260 and £364 respectively, on the ground that with the depreciation in the value of money attributable to the war, wages had increased with the result that members for whom the medical benefit was intended were being excluded from it; and the recruiting of members, a legitimate and necessary function of the societies, which depended very largely on the ability of the societies to offer medical benefit, was being impeded. The proposal was submitted to the medical officers of lodges through the local associations of members and the question of a correlative increase in remuneration for the medical officers was raised, based on the same decrease in the value of money and a corresponding rise in the cost of giving medical attendance. The matter was dealt with at the Annual (1920) Meeting of Delegates of the Local Associations with the Council, held on October 1; and, at a subsequent conference, held December 20, between the Council and the duly accredited representatives of the societies, it was agreed (see *The Medical Journal of Australia*, January 1, 1921, page 13) that the terms and conditions of attendance should be modified, as from April 1, 1921, as follows:

(1) The prescribed income limits to be £260 and £364, instead of £208 and £312 respectively as heretofore.
(2) The prescribed minimum rates to be:
  (*a*) For medical attendance only—
    In Sydney metropolitan area 26s., instead of 21s. (19s. in certain cases) as heretofore;
    Outside Sydney metropolitan area, 32s., instead of 26s. as heretofore.
  (*b*) For medical attendance and medicine—
    Outside Sydney metropolitan area 44s., instead of 34s. as heretofore.
(3) The fees for attending wives of members in their confinement and in cases of premature birth or miscarriage to be increased by £1 1s., making the minimum fee £3 3s., instead of £2 2s. as heretofore.

In accordance with the arrangements entered into at the same time the grand lodges notified their respective subordinate lodges of the new terms and conditions and the date of their commencement; and the necessary action was taken by the Council for the introduction of the amendment of the Common Form of Agreement by means of a "supplemental agreement" between the medical officer and the trustees of the lodge to operate as from the prescribed date, April 1, 1921.

(2) Interpretation of Common Form of Agreement. (*i.*) Clause 7: "Public Holidays." A question having arisen as to the meaning of the term "public holidays" in Clause 7 of the Common Form of Agreement, a lodge medical officer was advised by the Council to confine the holidays referred to to "public holidays universally observed, *viz.*, New Year's Day, Anniversary Day, Good Friday, Easter Monday, King's Birthday, Prince of Wales's Birthday, Christmas Day, Boxing Day."

(*ii.*) Clause 26: "Wife, if passed by the medical officer." In a case where a chemist objected to supplying medicine under his contract with the lodge where the medical officer had prescribed for a "wife" who had not been medically examined before being placed on his list for attendance (Clause 5), it was held that the objection was reasonable and the medical officer was advised accordingly.

(3) Regulations: Contract Attendance, Friendly Society Lodges. The following regulation (extraordinary general meeting, November 12, 1920) was added to the Regulations, Contract Attendance, Friendly Society Lodges, *viz.*:

> 24. Except with the express approval of the Council, no member shall have a name-plate or consulting room at any friendly society dispensary.

(*b*) Collieries.—The question of adjusting the rates for contract attendance on colliery employees to the increased cost of medical practice and of drugs, has been under consideration by the colliery medical officers in the areas of the Central Northern and South Eastern Medical Associations, as well as by those attending the western collieries. In some localities an increased rate of 1s. per week has been established. In others where the employees have the alternative of obtaining their medical benefit through the friendly society lodges, the minimum prescribed rate for which has been fixed at 44s. per annum, it is understood that a rate equivalent to this has to be determined, having regard to the fact that the colliery rate has hitherto covered certain obligations on the part of the medical officer, which, in friendly society lodge practice, come under the head of "special services," payment for which is a matter of arrangement between the medical officer and the friendly society lodge member. It is understood that there is no reluctance on the part of the colliery employees to pay a higher rate to meet the altered conditions of medical practice, if a reasonable increase can be agreed upon.

War Emergency Organization.—Although complications arising from the dislocation of the conditions of life and medical practice caused by the war, which have claimed so much attention during recent years, have abated, they have nevertheless called for constant consideration.

(*a*) Protection of practices of members who have been on active service abroad.—In two instances action by the Council was invited. In one it was found that there were considerations involved which were outside the province of the British Medical Association. In the other an interloping practitioner abandoned the position and failed to secure a successor.

(*b*) Medical Officers' Relief Fund (Federal).—The contributions to the Fund by the members of the New South Wales Branch now amount to £5,421 5s. 8d.. Recommendations were made to the Trustees by the Local Committee of Management for gifts and loans on behalf of five applicants.

(*c*) Repatriation to Germany of alien enemy practitioners.—An extraordinary general meeting of the Branch, convened in accordance with a requisition duly signed by 30 members who had served abroad in the war, was held April 20, 1920, at which resolutions were passed protesting against the continued delay in the repatriation to Germany of Dr. Max Herz (*Staats-examen*, Munich, 1899), who was interned during the war as being an alien enemy subject or otherwise dangerous to the community, and urging that a deputation wait upon the Prime Minister to lay the views of the profession before him (see *The Medical Journal of Australia*, 1920, Vol. I., p. 422). The resolutions were duly communicated to the Prime Minister, and, on June 18, a deputation, introduced by Dr. Earle Page, M.H.R., comprising 13 members of the Council and 7 representatives of the Society of Returned Medical Officers of New South Wales, was received by the Prime Minister at the Commonwealth Offices, Sydney. The Prime Minister promised the deputa-

tion that the matter would be re-considered without regard being had to the claim of Dr. Herz that he should be allowed to remain and practise in Australia on the ground that he had special skill in orthopædics not possessed by other practitioners. To a subsequent communication to the Prime Minister, dated September 8, 1920, a reply was received that the matter was under consideration. It is understood also that the Federal Committee of the British Medical Association in Australia (see *The Medical Journal* of Australia. February 19, 1921, p. 162) has been in communication with the Prime Minister, urging that, in the interests of the community, the practitioner referred to should be removed.

(*d*) Repatriation assistance to returned medical men.—This matter passed to the Federal Committee, which (see *The Medical Journal of Australia*, February 19, 1921, p. 161) has been successful in obtaining amendment of the regulations of some slight benefit to the returned medical men.

Legislation.—The Venereal Diseases Act of 1918 (New South Wales), the commencement of which was suspended, came into force throughout the State at December 1, 1920, in accordance with the proclamation published in the *Government Gazette*, November 20.

A *Medical Practitioners' Charges Bill*, providing for the taxation, under certain conditions, at the instance of the patient, of fees for attendance charged by legally qualified medical practitioners, was read a third time and passed in the Legislative Assembly on December 23, 1920.

Regulations.—In addition to the Regulation (Contract Attendance: Friendly Society Lodges, Reg. 24) referred to above, regulations of the Branch were made as follows:

Publication of Confidential Communications Between the Association and its Members.—Except with the express authority of the Council in writing, no member shall publish or be a party to publishing in any newspaper or otherwise the Memorandum, Articles of Association, By-laws or Regulations of the Association, or any portion thereof or extract therefrom, or any communication between him or any other member and the Association or the Council or a committee thereof, whether such communication be in regard to any matter under consideration by or submitted for the consideration of the Association or the Council or a committee thereof, or any Rule, decision or proceedings of the Association or the Council or a committee thereof, or any other matter.

Provided that it shall not be necessary to obtain such authority in respect of any such publication in the *British Medical Journal, The Medical Journal of Australia*, or other the official organ of the Association.

—Extraordinary General Meeting, March 26, 1920.

Annual Subscription.—On and after the 1st of January, 1921, the annual subscription of members of the Branch, except as hereinafter provided, shall be five pounds five shillings. Provided as follows:

(*a*) A member admitted on or after the 1st of July in any year shall pay half his current subscription for that year.

(*b*) In the case of a member admitted before the expiration of three years from the date of his registration as a legally qualified medical practitioner under any statute or otherwise, the annual subscription shall be three pounds three shillings until the 31st of December next occurring after the expiration of the period of three years from the date of such registration.

(*c*) A member who is over 70 years of age or who shall have permanently retired from medical practice, either in an official or any other capacity, shall pay three pounds three shillings, instead of five pounds five shillings.

(*d*) A member who shall have been registered as a legally qualified medical practitioner, and who is a permanent whole-time member of the Public Service of the Commonwealth (including the Naval and Military Services) or the State (including the New South Wales Government Railways and the University of Sydney) shall pay four pounds four shillings, instead of five pounds five shillings.

—Extraordinary General Meeting, December 10, 1920.

Names-Plates.—The following resolution, passed at a meeting of the Council, held October 5, 1920, was communicated to the members, November 19, 1920, namely:

(*a*) That a member who displays any specialty on his name-plate should not carry on general practice elsewhere.

(*b*) That the display of more than one specialty on on a name-plate be not allowed.

Post-Graduate Courses.—A suggestion was received from the Dean of the Faculty of Medicine that the Council draft proposals for post-graduate courses for adoption by the Faculty of Medicine; and the matter has been under consideration by the Organization and Science Committee accordingly. It is hoped that in a short time proposals will be formulated which will be acceptable to the Faculty. The first course will probably be in January, 1922, as it is recognized that, under present circumstances, January is the only month when the teaching hospitals and the university laboratories will be available for the instruction required.

Visit of H.R.H. Prince of Wales.—In accordance with a resolution of the Branch passed at the meeting held on April 30, 1920, an arch of welcome to His Royal Highness the Prince of Wales on the occasion of his visit to New South Wales in June, 1920, was erected by the Association, as one of the public bodies of the State, in College Street, Sydney. The net cost of the arch was £477 16s.. Of this sum £345 19s. 9d. was contributed by the members and the deficiency, £131 16s. 3d., was made up by the members of the Council.

Relationship between the Overseas Branches and the Parent Association.—Very careful consideration was given to the Annual Report of the Council (*British Medical Journal* Supplement, April 24, 1920, p. 109) in regard to the "question of possibility and desirability of taking further powers under the constitution of the Association whereby it might become in part a federation of medical bodies"; also to the report (*British Medical Journal* Supplement, July 3, 1920, pp. 7 and 8) of the proceedings of the Annual (1920) Representative Meeting. It was noted that the recommendations of the Council were adopted to the effect that the Articles and By-laws be amended to enable the Association, without abandoning its present position as an Association of individual members of the medical profession, to become in addition a federation of medical bodies. It was noted also that it was arranged that a conference of representatives of the overseas Branches with representatives of the Association at home should be held in England in July, 1921, with the object of arriving at a full agreement as to what should be the lines of the proposed Articles and By-laws. Approval was given at an extraordinary general meeting of the Branch held October 29, 1920, to a proposal made by the Federal Committee that a representative of the Branches in Australia should be sent to England to act at the conference referred to.

Federal Committee.—The Federal Committee of the British Medical Association in Australia met in Brisbane, August 25, 1920, and in Melbourne on February 1 and 2, 1921. Reports of the proceedings were published in *The Medical Journal of Australia*, 1920, Vol. II., p. 252, and 1921, Vol. I., p. 160.

(Signed) C. BICKERTON BLACKBURN.

President.

Financial Statements.

The Honorary Treasurer, Dr. W. H. Crago, submitted the statement of receipts and expenditure for the year 1920. He pointed out that the receipts were larger than those of any previous year. He regretted that the necessity had arisen for increasing the members' subscription, but he was pleased to announce that only three members had resigned on this account and that the subscriptions were coming in well.

Dr. W. H. Crago also presented the financial statement of the Premises Account. The profits on the year's undertakings after deduction of all disbursements amounted to £671 4s. 8d.. The gross revenue had been larger than that of 1919, but the expenditure had also been greater. Repairs and redecorating had cost the considerable sum of £206, while wages has also gone up. The usual sum of £1,000 had been paid off the mortgage. If all went well,

NEW SOUTH WALES BRANCH.

Receipts and Expenditure for the Year Ended December 31, 1920.

Receipts.

	£	s.	d.
To Balance Forward	254	18	4
„ Subscriptions	4,765	11	6
„ Interest	24	8	3
„ Sales (C.F.A.)	14	15	6
„ Exchange and Discounts	8	12	1
	£5,068	5	8

Expenditure.

	£	s.	d.
By Parent Association	1,315	13	0
„ *The Medical Journal of Australia*	1,247	10	0
„ Office Salaries	878	0	0
„ Premises Account	200	0	0
„ Printing and Stationery	164	6	3
„ Stamps (Postage and Duty)	149	11	0
„ Rent £150 0 0			
„ Less Sublettings 67 10 0			
	82	10	0
„ Assistant Librarian	67	0	0
„ Sundries	54	4	8
„ Telephone	17	15	0
„ Cleaning	19	2	6
„ Attendance at Meetings	25	6	4
„ Bank Charges and Exchange	10	8	0
„ Travelling Expenses	6	10	10
„ Balance Cash Book £827 5 4			
„ Balance Petty Cash 3 2 9			
	830	8	1
	£5,068	5	8

Examined and found correct,

A. MAITLAND GLEDDEN
FRED. W. HALL
Auditors.

W. H. CRAGO,
Honorary Treasurer.

the building would pass unhampered into the hands of the Branch and of the debenture holders in the course of nine years. In seconding the reception of this statement, Mr. J. Adam Dick, C.M.G., congratulated Dr. Crago on the very satisfactory financial position of the undertaking.

Dr. Crago moved and Dr. R. H. Todd seconded a vote of thanks to Dr. A. M. Gledden and Dr. F. W. Hall for their services as honorary auditors. Later in the evening the same gentlemen were re-elected auditors for the ensuing year.

Presidential Address.

The retiring President, Dr. C. Bickerton Blackburn, then read his address (see page 259).

Dr. Fourness Barrington moved a vote of thanks to the President for his admirable address. He stated that it was a privilege and a pleasure to have the opportunity of proposing this motion. He had derived profit for the able and thoughtful utterances of the President. He expressed the hope that Dr. Blackburn would continue to give to the Branch the advantages of his philosophical advice and valuable experience. The motion was carried by acclamation.

Election of Office-Bearers.

The President announced the result of the election of the office-bearers and members of the Council as follows:

President: Dr. Fourness Barrington.

Vice-President: Dr. T. W. Lipscomb.

Members of Council: Dr. George Armstrong, Dr. J. E. V. Barling, Dr. C. B. Blackburn, Dr. A. J. Brady, Dr. W. H. Crago, Dr. F. Brown Craig, Dr. Andrew Davidson, Dr. J. A. Dick, Dr. Sinclair Gillies, Dr. Sydney Jamieson, Dr. C. H. E. Lawes, Dr. W. F. Litchfield, Dr. W. C. McClelland, Dr. A. A. Palmer, Dr. S. A. Smith, Dr. D. Thomas, Dr. R. H. Todd, Dr. R. B. Wade.

Dr. Blackburn called the attention of the members to the fact that the name of Professor F. P. Sandes was not among those nominated for election. Professor Sandes had intimated that his manifold duties would render it impossible for him to devote time and energy to the work of the Council. He asked the members to pass a vote of thanks to Professor Sandes for his valuable services to the Council and to the Branch. The motion was carried by acclamation.

On the motion of Dr. Fourness Barrington, seconded by Professor Sandes, a hearty vote of thanks was accorded to the scrutineers, Drs. A. J. Aspinall, G. Bell, A. J. S. Brandon, J. G. Edwards, A. J. Gibson, A. M. Gledden, H. S. Marsh and H. A. Ridler.

Dr. Fourness Barrington moved and Dr. F. Brown Craig seconded a motion to the effect that Dr. R. H. Todd be the Representative of the Branch at the Representative Meeting of the British Medical Association to be held in Newcastle in July, 1921, and that Dr. R. Gordon Craig be the Deputy Representative. The motion was carried. It was further resolved that Dr. R. Gordon Craig, Dr. R. H. Todd and Dr. J. C. Douglas be appointed delegates to attend the annual meeting of the British Medical Association at Newcastle.

The Medical Benevolent Fund of New South Wales.

In the absence of Sir Herbert Maitland, Professor Sandes presented the financial statement of The Medical Benevolent Fund of New South Wales (see page 280).

He further moved that the following gentlemen be re-elected members of the Committee, Dr. T. H. Fiaschi, D.S.O., V.D., Dr. F. W. Hall and Dr. J. Macdonald Gill. The motion was carried.

Induction of President.

Dr. C. Bickerton Blackburn said that he realized that there was no need for him to introduce to the members his successor, Dr. Fourness Barrington. It was ridiculous to attempt to speak of the benefits which would be conferred on the Branch by having Dr. Barrington as their President. His wisdom and common sense were valuable assets of the Branch. They were fortunate in their choice of President.

In passing to the Chair, Dr. Fourness Barrington thanked Dr. Blackburn for the nice things he had said of him. He appreciated the high honour his colleagues had done him in electing him to the position of President. He promised to do his best during his term of office and trusted that with the help of the Council things would be well. Dr. Blackburn had spoken almost regretfully that his term had been placcid. He trusted that the calm would be continued unruffled during the next twelve months.

MEDICO-POLITICAL.

An extraordinary meeting of the New South Wales Branch was held in the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on March 18, 1921, at the conclusion of the annual meeting, Dr. Fourness Barrington, the President, in the chair.

Financial Statement of The Medical Benevolent Fund of New South Wales.

Dr. 1920.	£ s. d.	1920.	£ s. d.	Cr. £ s. d.
Balance Brought Forward from March 31, 1919	182 5 1	Money Disbursed to Deserving Cases, as Directed by Committee		32 0 0
Subscriptions from March, 1919, to March, 1920	37 17 6	Bank Fees		10 0
		Bank Exchange		3 6
		Cheque Returned from Bank		10 6
		Printing and Postages		12 1 6
		Balance as per Pass Book	£222 1 1	
		Less Cheque to Sir Herbert Maitland for cash paid out of his own pocket	47 4 0	
				174 17 1
	£220 2 7			£220 2 7
At Deposit in Savings Bank of New South Wales, as per Pass Book, plus Interest to June 30, 1920				337 16 0
Balance at Credit Current Account at Commercial Banking Company of Sydney, as per Pass Book				174 17 1
Total Credit				£512 13 1

Audited and found correct, H. L. MAITLAND, Honorary Secretary. GEORGE BELL.

Dr. W. H. Crago, the Honorary Treasurer, moved:

That the Memorandum of Association of the Company be altered as follows, *viz.*: In Clause 4 by substituting the words "six pounds" for the words or figures "£5."

Dr. Crago explained the significance of the proposed alteration which would have the effect of enabling the company to pay 6% on debentures or other borrowed money instead of 5% as at present. The motion was seconded by Dr. Fourness Barrington and carried.

Dr. R. H. Todd moved:

That the Articles of Association be altered as follows, *viz.*:

(*a*) In Article 64 the words "would be delivered in the ordinary course of post" be deleted and the words "was put into the post office" be inserted in their place.

(*b*) In Article 64 at the end thereof the following words be added, namely:

Where a given number of days' notice or notice extending over any other period is required to be given the day of service shall unless it is otherwise provided be counted in such number of days or period.

(*c*) In Article 16 the word "nine" be substituted for the word "seven."

(*d*) In Article 16 at the end thereof the following words be added, namely:

When it is proposed to pass a special resolution the two meetings may be convened by one and the same notice and it shall be no objection to such notice that it only convened the second meeting contingently on the resolution being passed by the requisite majority at the first meeting.

Dr. Todd explained that this motion had been brought forward for the purpose of removing an anomaly in the present arrangements. If the amendment of the Articles suggested were approved, the difficulty concerning the time occupied by the transmission of a notice of meeting by post to members living at remote corners of the State or outside the State would be removed.

Dr. C. Bickerton Blackburn seconded the motion, which was carried without dissent.

Harry Macgregor Cutler, Esq., M.B., Ch.M., 1920 (Univ. Sydney), of "Vineta," Woolwich Point, has been nominated for election as a member of the New South Wales Branch.

PUBLIC HEALTH IN SAMOA.

The New Zealand Government has published the regulations under the *Health Act* providing for a department of public health in Western Samoa. The members of the Board will be the Administrator of Samoa, the Chief Medical Officer who is to be the official head of the department and whose duties will include the control of the division of clinical medicine and the division of hospitals, the Medical Officer of Health, who will be placed in charge of the preventive and sanitary activities of the Board, and the Engineer in charge of public works.

The duties of the Board have been framed in such a manner as to include, in addition to the ordinary functions of a health department, the investigation into the causation and possible prevention of tropical and other diseases. In order that the investigational side of the work may be developed along scientific lines, the Government has decided to appoint a pathologist skilled in research and to erect in Apia a set of modern research laboratories. The value of this appointment is enhanced by the fact that the London School of Tropical Medicine commissioned Dr. F. W. O'Connor some time ago to investigate the disease filariasis in the Gilbert and Ellice Islands and elsewhere in the Pacific. Dr. O'Connor has been conducting valuable researches with meticulous care, first at Funafuti, then in the other islands of the group and more recently in Western Samoa. He has now been appointed Pathologist to the Samoan Government. The staff will further include a resident medical officer at the Public Hospital at Apia. Lastly, there will be a secretary to the Board, a hospital steward, a number of native sanitary inspectors and such other officers as the Board may find necessary. The programme appears to be an ambitious one. We may anticipate considerable progress in tropical medicine from its activities.

Correspondence.

PAPILLŒDEMA.

Sir: Unfortunately I was not able to be present at the Brisbane Congress and have only just known of and read the letter of my old friend and colleague, Dr. Mills, on papillœdema.

While in general in thorough accord with the views expressed by Professor Mills, there are one or two points in the paper that I would crave permission to refer to.

In the second paragraph of his letter he says: "I am glad to say that proposed amendments to the curriculum of the Sydney Medical School will more specially require of our students a knowledge of the commoner diseases of the eye." Anyone reading this wording might conclude that there is no teaching of diseases of the eye in the University. As a matter of fact, almost since the inauguration of the Medical School there has been a course on ophthalmology and, if I mistake not, Professor Mills was one of the earliest students and one who has done great credit to the teaching, inasmuch as he has followed it up and made himself proficient in the use of the ophthalmoscope. Up till about 15 years ago (I am speaking from memory) the course on

ophthalmology was compulsory. It was then made optional, a step which I considered a very retrograde one and have several times urged that the course be again made compulsory. Although voluntary, as many students as possible avail themselves of the course and this year 135 names were on my class roll.

While agreeing that Professor Mills is right in his contention that the term "optic neuritis" is not suitable for many of these cases, I do not like the term "papillœdema." For two reasons: In the first place, the optic disc is not a papilla and in the second place, the term is a mongrel one, being a combination of a Latin and a Greek word. If a single word be desired, I might suggest the word "kuklœdema," a combination of two Greek words: κυκλος—a disc, οἰδημα—swelling. But what is wrong with the old term "choked disc," which you use in your leading article on Dr. Mills's paper? It expresses the pathology of the condition, has fewer words and fewer syllables than either of the other single words above referred to.

The suggestion which Professor Wilson made to Dr. Mills, to relieve the intracranial pressure by opening the optic nerve sheath was advocated and, I think, performed over 30 years ago, if my memory serves me right, by Brudenell Carter, but nothing further has come of it. In any case, this is an operation requiring a considerable amount of operative skill and is not devoid of risk. Either lumbar puncture or even craniotomy (which, by the way, Dr. Mills does not refer to and which relieves pressure in many cases where lumbar puncture has failed) is a simpler operation. Undoubtedly, intracranial pressure is a large factor, probably the chief factor in causing choked discs, but I am of opinion that it is not the sole cause. We have the fact that in chronic hydrocephalus, where the pressure is so great as to distend the skull, choked disc very rarely occurs. Of course, it may be argued that that is due to the fact that the pressure is raised slowly. I have for years taught that probably increased intracranial pressure, combined with some chemical changes in the cerebro-spinal fluid induced by the growth, causes the choked discs; also that failure to relieve the condition by a decompression operation might be regarded as negligence.

There are many points in reference to the connexion between choked discs and cerebral growths which are puzzling and which cannot be explained by the pressure theory. For example, we know that very small growths in certain parts of the brain often induce intense swelling of the discs, whereas much larger, rapidly growing tumours in other parts often fail to produce choked discs, or if they do, this occurs only late in the course of the disease. I recollect one interesting example of this. A young, married lady had a sarcoma of one frontal lobe, nearly as large as a goose egg (verified at *post mortem* examination) and until a few days before her death had no ocular indication of the presence of a growth and no other signs beyond moderate headache and her attendant, the late Dr. Dagnall Clarke, one of the most accomplished physicians we ever had here, was not able to diagnose the trouble until the œdema of the discs showed itself a few days before death. On the other hand, very small tumours in the cerebellum and other parts of the brain are generally accompanied by very severe choked discs. There are many other interesting points which one would like to discuss, such as the contralateral and isolateral theory, but space forbids.

In regard to Dr. Stawell's suggestion, quoted in your leading article, one of my former students, now a leading ophthalmic specialist in Sydney, reminds me that that was made by me in my lectures nearly 30 years ago and that I also suggested that the difference in intensity of the swelling in the two discs was probably due to anatomical causes or perhaps to the locality of the growth.

Yours, etc.,

(Undated). F. ANTILL POCKLEY.

URETHRAL IRRIGATION.

Sir: I have read with much interest Dr. J. Forbes Mackenzie's article in your issue of March 26, 1921, entitled "A Word About Urethral Irrigations" and would like to know what alternative treatment he uses in preference to the irrigations he condemns. There remain practically only two: the "gauze pack" method of Fogarty and the method of leaving the urethra alone and giving alkalies, etc.. Now I have asked several returned men about the "gauze pack" method and none has a good word to say for it. As regards the method of "do nothing," I have read plenty of Royal Army Medical Corp statistics and find that the average duration of cases properly irrigated is shorter than those in which no irrigation was practised. The comparison between the ball poised on the fountain jet and the urethral débris at the end of the irrigation column is very interesting, but has the writer any more convincing data about a better method of treatment?

Yours, etc.,

J. W. SUTHERLLAND.

Narromine, New South Wales,
March 26, 1921.

SUBSCRIPTIONS.

Sir: I received the usual subscription notice from the Secretary of the Victorian Branch of the British Medical Association this year and seeing the amount (£4 4s.) concluded that a clerical error had been made, as I had not been notified of any intended change in the amount. Having learnt since that the subscription had been raised to £4 4s. in order to meet increased charges outside Australia, I wish to protest against this imposition and the manner in which it is proposed to introduce it.

It is a good thing, no doubt, to maintain our local association to look to the interests of the members generally and also to keep us informed on medical topics by means of the *Journal*, but the latest demand seems out of all proportion to the benefits conferred.

Yours, etc.,

J. A. BISSET.

16 Collins Street, Melbourne,
March 24, 1921.

PAYING HOSPITALS.

Sir: I note with satisfaction that the staffs on the English hospitals are waking up to their position and are insisting on receiving some material recompense for their services in respect to patients who can pay something in excess of mere costs of maintenance. The class of patient indicated is by far the most numerous in Australian hospitals and should be specially provided for by means of a scale of charges for service suited to the circumstances of each case. It seems to be feared that any system of payment to the staff will result in deterioration of the quality of medical work generally, but this surely is not borne out by facts. During recent years many members of the staffs of civil hospitals transferred their services to military hospitals, leaving the delights of rendering service to the "necessitous poor" at the former institutions to temporary officers. It is not suggested that the military pay was any attraction, but I understand that these officers were extremely businesslike in collecting the last dollar and I'm sure that they would resent any suggestion that the quality of their work had deteriorated in any way. It will be accepted, I think, that any medical officer whose work could be affected adversely by such causes, would be not much good anyway and the "more pay, poorer work" idea is a mere bogey.

Yours, etc.,

MEDICAL STAFF.

(Undated.)

Proceedings of the Australian Medical Boards.

VICTORIA.

The undermentioned gentleman has been registered, under the provisions of Part I. of the *Medical Act, 1915*, as a duly qualified medical practitioner:

Robert Jamison, M.B., B.S., B.A.O., R.U., Irel., 1906, F.R.C.S., Eng., 1910, c/o. P. P. Wilcocks, 280 Bourke Street, Melbourne.

The following additional qualification has been registered:

George Alexander Birnie, D.P.H., Lond., 1919, M.D., Melb., 1920.

The name of the late Dr. Alfred Austin Brown has been removed from the Register.

SOUTH AUSTRALIA.

The undermentioned have been registered, under the provisions of the *Medical Act, 1880*, as duly qualified medical practitioners:

Francis Julian Bowyer Miller, M.B., B.S., Melbourne, 1916.
William Dixon Saltau, M.B., B.S., Melbourne, 1918, M.D., Melbourne, 1920.

The undermentioned additional degrees have been registered:

William Clifford Sangster, M.D., Melbourne, 1911.
Frederick Neill Le Messurier, M.D., Adelaide, 1920.

Medical Appointments.

The appointment is announced of Dr. F. C. Rogers (B.M.A.) as Honorary Surgeon, of Dr. L. G. Tait (B.M.A.) as Honorary Assistant Surgeon and of Dr. C. Nigel Smith (B.M.A.) as Honorary Relieving Medical Officer to the Royal Alexandra Hospital for Children at Camperdown, Sydney.

Dr. P. F. Shanahan (B.M.A.), of Curramulka, has been appointed an Officer of Health under the provisions of the *Health Act, 1898*, of South Australia.

The appointment of Dr. Cass (B.M.A.) as Medical Officer of Health to the Meekathara Road Board of Western Australia has been approved.

The appointment of Dr. E. A. Joske (B.M.A.) as Government Medical Officer at Balranald, New South Wales, has been approved.

Dr. Earle Page, M.P. (B.M.A.), has been appointed Honorary Surgeon to the Coast Hospital at Little Bay, New South Wales.

The appointment as District Medical Officers and Public Vaccinators of Dr. A. A. Crooks (B.M.A.) at Wickepin, of Dr. T. J. Hennessy at New Norcia, of Dr. R. Andrews (B.M.A.) at Nannup and of Dr. H. R. Smith (B.M.A.) at Cue, is announced in the *Government Gazette of Western Australia*.

Dr. E. C. East (B.M.A.) has been appointed Honorary Medical Officer in charge of the treatment of venereal disease at the Fremantle Public Hospital, Western Australia.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxv.

Commonwealth Public Service: Quarantine Branch: (*a*) Six Medical Officers. (*b*) Six Junior Technical Assistants.

Public Service Board, Sydney: Resident Medical Officer, Avon Dam Camp.

Royal Alexandra Hospital for Children, Sydney: Two Honorary Assistant Surgeons.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C..

Branch.	APPOINTMENTS.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society.
VICTORIA. (Hon Sec., Medical Society Hall, East Melbourne.)	All Institutes or Medical Dispensaries. Manchester Unity Independent Order of Oddfellows. Ancient Order of Foresters. Hibernian Australian Catholic Benefit Society. Grand United Order of Free Gardeners. Sons of Temperance. Order of St. Andrew. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

Apr. 6.—Vic. Branch, B.M.A..
Apr. 8.—N.S.W. Branch, B.M.A., Clinical.
Apr. 8.—Q. Branch, B.M.A., Council.
Apr. 8.—S. Aust. Branch, B.M.A., Council.
Apr. 12.—Tas. Branch, B.M.A..
Apr. 12.—N.S.W. Branch, B.M.A., Ethics Committee.
Apr. 14.—Vic. Branch, B.M.A., Council.
Apr. 15.—North-Eastern Med. Assoc. (N.S.W.), Annual.
Apr. 19.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Apr. 20.—W. Aust. Branch, B.M.A..
Apr. 22.—Q. Branch, B.M.A., Council.
Apr. 22.—Western Med. Assoc. (N.S.W.).
Apr. 26.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Apr. 27.—Vic. Branch, B.M.A., Council.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: B. 4685.)